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ABSTRACT

This handbook and study guide were developed as a textbook to be used as a review course for preparation for the clinical licensing examination. It presents a summary of a graduate level academic program in clinical mental health counseling. It contains 17 chapters on clinical information; 4 chapters on test taking; 2 types of sample tests; and 3 varieties of additional study tools. Each content chapter provides information outlining assessment procedures and assessment materials; the mental status examination content; the history and framework of the Diagnostic and Statistical Manual system; and summaries of Axis I and Axis II disorders. The treatment planning section provides information about the theoretical approaches used, treatment techniques used, and medications appropriate for each disorder. Special attention is given to the clinical areas of special treatment issues, psychopharmacology, and substance abuse. Professional practice and the comprehensive, legal, and ethical framework of a mental health counselor's practice are also examined. The Test Taking section provides a personalized approach to study skills. Case scenarios allow for a review of information in the case study format. Study cards are included for easy reference and further study. (Contains over 300 references.) (JDM)

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CLINICAL MENTAL HEALTH COUNSELOR

Handbook & Study Guide

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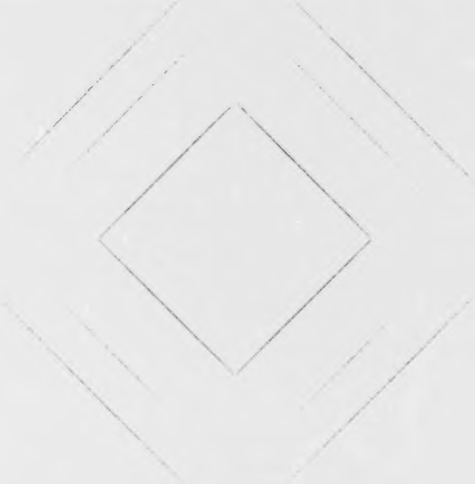

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CLINICAL MENTAL HEALTH COUNSELOR

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Handbook & Study Guide

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TABLE OF CONTENTS

Foreword vii
Preface ix
Acknowledgments xi
Introduction xiii
Important Information: Please Read xvii

Part I
Content Areas 1

1. Growth and Development 3

Heredity vs. Environment • Sensitive Periods • Clinical Issues • Cognitive Development Theories • Other Factors: Language Development • Age and Life Span • Gender Effects

2. Personality and Social Development 9

Theories of Personality Development • Moral Development • Other Issues: Attachment • Sex Role Development • Family Factors • Age Factors

3. Assessment 21

The Role of the Clinician • Types of Tests • Ability Testing • Personality Testing • Projective Tests • Behavioral Assessments • Family Assessments • Values Assessments • Aptitude Tests • Achievement Tests • Career Assessment Instruments • Self-Concepts Personal Constructs and Self-Reports • Common Terms

Mental Status 43
Client Evaluation • Psychological Interview • Mental Status Examination • The Clinical Report • Mental Status Assessment Worksheet

4. Diagnosis 53

DSM-IV: History • Definition of a Mental Disorder • Description of Axes I-V • Other Concepts Used in Diagnosis • The 17 Diagnostic Categories of Axis I, Axis II, and Axis I—Not Mental Disorders • Summary of Key Changes from DSM-III-R • 10 Steps to Diagnosis

5. Treatment Planning 81

Theoretical Approach, Treatment Techniques, and Medication Used for Each Diagnostic Category on Axis I • Theoretical Approach, Treatment Techniques, and Medication Used for Each Diagnostic Category on Axis II

6. Counseling Theories 115

Psychodynamic Psychotherapies • Behavior Therapy • Cognitive-Behavioral Therapy • Humanistic Therapies • Reality Therapy • Transactional Analysis • Existential Psychotherapy

Family Therapy 121
Definition of Family Therapy • The Development of Family Therapy • Objectives of Family Therapy • Major Contributors to Family Therapy • Types of Family Therapists • Major Indications for Family Therapy • Techniques in Family Therapy

Group Therapy 134
History • Advantages of Group Therapy • Types of Groups • Leaders in the Field • Group Leadership Skills

7. Treatment Modalities 147

Family Therapy • Group Therapy • Individual Therapy • Crisis Intervention • Conflict Resolution/Mediation

8. Special Treatment Issues 151

Child Abuse and Neglect • Domestic Violence • Suicide • Counseling Specific Populations: Counseling Elderly Populations • Minority Group Clients • Clients with Physical Disabilities • Lesbian and Gay Clients • Gender Issues

9. Substance Abuse 161

History • Definitions • Diagnosis • Differential Diagnosis • Dual Diagnosis • Stages of Substance Abuse • Treatment • Specific Substances

10. Psychopharmacology 185

Introduction • Important Concepts • Psychiatric Drugs: Antipsychotics Major Tranquilizers and Neuroleptics • Minor Tranquilizers . . . Anxiolytics • Antidepressants • Mood Stabilizers • Sedatives-Hypnotics • Barbiturates • Ethyl Alcohol • Opioid-Analgesics • Amphetamines • Methylphenidate • Cocaine • Hallucinogens and LSD • Professional/Clinical Issues

11. Research and Evaluation 205

Research Design: Research Process • Research Design Concepts • Kinds of Research • Research Strategies • Threats to Validity • Group Designs • Single-Subject Designs

12. Statistics 211

Descriptive Statistics • Inferential Statistics

13. Outcome Studies 219

Overview of Outcomes Research • Therapeutic Alliance • Therapist Variables • Client Variables • Treatment Factors • Other Client Issues

14. Prevention 225

Primary Types of Factors: Risk Factors • Protective Factors • Other Factor Systems • Objectives of Prevention • Strategies of Intervention

15. Career Development 229

History • Integration into Counseling Practice • Career Theories • Leaders in the Field • Career Counseling Competencies • Computer Assisted Career Guidance Systems • Key Terms

16. Organizational Consulting 239

Ethics of Consulting • The Rights of Consultees • Organizational Development • Consultation Competencies • The Consultive Process

17. Professional Practice 245

Quality of Care • Unprofessional Conduct • Malpractice • Legal Ethical • Reporting • Referral and Consultation • Record Keeping

Part II
Test Taking 261

18. Test Taking 263

The Workshop • Study Plan: Study Skills and Strategies • Focus and Personality Style • Attitudes and Reframing Attitudes • Using the Written Study Material, The Examination • Eustress Rather than Distress • Reducing Anxiety • Preparing for the Examination Day • Recommendations

19. MindMapping 279

Using All Your Mental Tools to Create, Organize and Use Information • Getting Started • MindMapping to Assess Cases • Mind Map of Content Areas • Approaching a Scenario

20. Personality Type 285

The MBTI Personality Types • Applying Preference Types to Help Pass the Exam

21. Key Answers 289

Prioritized Responses for Particular Clinical Issues • Key Words and Answers

22. Scenarios 301

Approaching the Scenario: The Eleven Phase Model • Multiple Choice Study Cases • Case Studies with Questions and Answers

23. Simulations 343

About the Clinical Simulation Test Format • Sample Simulation • Sample Scoring Sheet • Clinical Simulations and Scoring Sheets

Part III
Tools 365

Time Management Forms 367
Tools for Self-Management to Help Pass the Examination: Time Log • Schedule Weekly • Schedule Monthly • Schedule Daily • Plan Milestone • Journal • Action

Bibliography 375

Index 385

Crossword Puzzles
Assessment • Career • Counseling Theories • Diagnosis 1 • Diagnosis 2 • Family Therapy • Group Therapy • Growth and Development • Personality Theories • Prevention • Professional Practice • Psychopharmacology • Research • Statistics • Substance Abuse 1 • Substance Abuse 2 • Treatment Issues • Treatment Planning • Answers

Flashcards
How to Use Flashcards • Key to Flashcards • Flashcard Set

FOREWORD

This publication is a most welcome addition to the mental health counselor's library and I highly recommend the *Clinical Mental Health Counselor Handbook and Study Guide.*

The handbook and study guide was developed as a textbook to be used as a review course for preparation to take the clinical mental health counseling licensing examination and is a summary of a graduate level academic program in clinical mental health counseling. The volume was written by mental health counselors with over twenty years of experience in clinical practice.

The Clinical Mental Health Counselor Handbook and Study Guide was developed by the Professional Training Institute and is sponsored and supported by the American Mental Health Counselors Association and published by the Kendall-Hunt Publishing Company.

This important publication is essential for working in today's complex managed care environment. The book creates a unifying framework for the wide range of topics covered in graduate level academic programs in clinical mental health counseling and at the same time answering the theoretical and professional practice questions clinicians face on a daily basis.

I trust you will find this publication a most useful tool today, and as a professional reference manual for many years to come.

W. Mark Hamilton, Ph.D.
Executive Director
AMHCA
July 1998

PREFACE

The *Clinical Mental Health Counselor Handbook and Study Guide* was developed by Licensed Mental Health Counselors to meet a two-fold need in the mental health field. First, the workbook was developed in response to the need of counselors for material summarizing their graduate level course work in studying for their licensing examination at the state and national levels. Secondly, the mental health counselor guide was designed to be useful to Professional Counselors as an integral part of their professional library. *The Handbook and Study Guide* answers many everyday questions that arise in the course of our work in the mental health field. It represents the latest research, and provides a broad spectrum of various and, sometimes, conflicting views in the field.

There are many ways to use this book. If you are using it as a workbook for studying for your licensing examination, you will find the content material enhanced by use of information regarding your learning style, test-taking techniques, the study time-sheet, and the flash cards. The crossword puzzles are fun and make learning and remembering the material more enjoyable. *The case simulations will help you to anticipate what to expect on the test, how it will be presented, and how you should think about the information given.*

For those of you in private practice, we are finding some Managed Care companies ask potential panel members to review a case scenario and provide a full five-axis DSM-IV diagnosis and treatment plan. The case scenarios provide you with the tools to show your clinical expertise.

If you are using the *Handbook and Study Guide* for your professional library, the broad scope of content areas collected and organized together in a single volume is cost and time efficient. The extensive bibliography enables you to do additional research on questions you may have, or to help you obtain further information.

In whatever way you use this book, we believe you will find it a valuable resource. We are always interested in your feedback and would like to hear from you regarding the book or other information that would be helpful to us in future revisions.

ACKNOWLEDGMENTS

We would like to thank the 700+, successfully Licensed Mental Health Counselors in Massachusetts who have taken our course, used this *Clinical Mental Health Counselor Handbook and Study Guide* over the last four years, and given us invaluable feedback about its content and organization. We would also like to thank the Massachusetts Mental Health Counselors Association for offering us the opportunity to develop the course and the Handbook. We thank the American Mental Health Counselors Association, for their leadership and strong support for the highest professional standards in the education, training and professional practice of mental health counselors. We also thank AMHCA for helping us bring what we believe is a valuable professional aide to mental health counselors nationwide.

INTRODUCTION

This book began and grew from a void. When mental health counselors in Massachusetts obtained licensure in 1987, we had many ecstatic moments celebrating the victory of our recognition as professionals and our successful professional future. In the Summer of 1991, as our first Massachusetts licenses were being issued and we looked ahead to the advent of licensure examinations, some of us realized that the taking of an examination as comprehensive and important as the examination for licensure necessitated studying an enormous amount of material (in fact, each course in a whole graduate program).

Linda Lawless, a Board Member and Past-President of MaMHCA, the Massachusetts Mental Health Counselors Association, had experienced this tedious and excruciating study process prior to taking her Marriage and Family License exam in California. She became enchanted with the idea of creating a course for mental health counselors that would eliminate the need to re-read every text-book on every subject that would be covered by a potential exam. She had measured her old MFT study materials in feet and was determined to develop a better and more efficient way for Mental Health Counselors to focus their studying for the licensure examination. Midge Williams, MaMHCA President in 1994, asked the MaMHCA Board to support the licensure effort and provide an important professional development service to members by sponsoring a workshop to prepare mental health counselors for the license examination. The Board agreed and asked Linda Lawless and Bonnie Bullard, who had both conducted other MaMHCA sponsored Professional Development Workshops, to develop a License Examination Preparation Workshop. At that time, there was no course or study book available that spoke to the specific clinical mental health counselor examination that was used in Massachusetts (As far as we know, the PTI Handbook and Exam Preparation Workshops are still the only study options that prepare candidates for the NCCMHCE). We all believed that a course could be designed that would cover the appropriate material and make that material available in a focused and concentrated way. Of course, for a course, there needs to be a textbook available to study. And to prepare for a test, there needs to be practice tests. And here you have it! This study guide contains these materials.

Developing these materials has not been simple. This *Handbook* has had many transformations. It has been completely re-written four times in the last four years, revising, editing, adding, and deleting material in order to be both comprehensive, pertinent, focused and compact. During this elaborate process, Midge Williams joined our writing team, and Deborah Bergstrom joined the partnership as our production coordinator. We reviewed all the clinical content many times over. Several experienced mental health counselors and counselor educators reviewed the Handbook. We labored over the serious responsibility and exacting process of constructing the sample tests. Unexpectedly, we developed new expertise in the realm of printing and publishing. And finally, with 17 chapters on clinical material, 4 chapters on test-taking itself, two kinds of sample tests, and three varieties of additional study tools (crossword puzzles, flashcards, and time management forms) we now believe we have a *Handbook* which is not only useful as the text for the examination preparation course we conduct in Massachusetts, but is a "stand alone" text for home study in preparation for the National CCMHC Examination. This workbook is the foundation for examination preparation workshops and self-study that have helped hundreds of mental health counselors pass the licensing/certification examination.

Each content chapter is a summary of the major points of each class in a comprehensive (using the CACREP standards/guidelines) graduate mental health counseling program. We felt it important to begin with an overview of the fundamentals—theories of growth and development and theories of personality and social development—prior to getting in to direct, applied clinical material. The several chapters on direct clinical material: assessment, diagnosis, counseling modalities and theories, and treatment planning are much more detailed and inclusive, providing the backbone of the clinical material that the examination covers. These chapters provide information outlining assessment processes and assessment materials, the mental status examination content and process, the history and framework of the DSM system, as well as summaries of all the Axis I and Axis II disorders. The treatment planning section provides information about the theoretical approach(es) used, treatment technique(s) used, and medication(s) for each diagnostic category. Again, for essential background knowledge, summaries of the major treatment modalities and the major counseling theories follow. We then focus on three selected clinical areas for an even more detailed review: special treatment issues, psychopharmacolgy, and substance abuse. These clinical areas are of particular importance in practice today. Research and evaluation, statistics and outcome studies are then reviewed, as a growing focus in all practice management. Prevention, career development, and organizational consulting are reviewed as the next tier of practice information. Last in the content section is professional practice, covered in considerable detail, as the comprehensive, responsible, legal and ethical framework for mental health counselor practice.

In addition to providing a thorough content review, we all felt it would be especially important to provide information about test-taking in general, and test-taking for this test in particular. The Test Taking section provides a personalized approach to study skills (using the MBTI framework), creativity tools to help gather and organize disparate information (MindMapping techniques), and three kinds of testing formats to help you assess your knowledge base. The crossword puzzles provide an engaging and creative approach to testing your knowledge in specific clinical mental health content areas. The case scenarios allow you to review information in the case study format and work on information retrieval (using the Key Answers method) in the short answer, multiple choice format. The case simulations provide you with the actual format of the clinical interview simulation format, the current format of this test. The Test Taking section walks you through both analyzing the skills and the information needed to approach these test formats. Lastly, with our flashcards we have provided you with over 200 study cards highlighting the key words and major concepts from all the content chapters in the

Handbook and Study Guide. They are notated to the *Handbook* for easy reference and further study.

It's been a long journey for us in bringing the *Clinical Mental Health Counselor Handbook and Study Guide* to you. We hope you find it a valuable asset in your journey preparing for your licensure or certification examination. We also hope it will have a future as a valuable reference in your professional library.

Good Luck!

Bonnie M. Bullard
Linda L. Lawless
Midge Williams
Deborah Bergstrom

Boston, MA
June 1998

IMPORTANT INFORMATION
PLEASE READ

This volume covers all the material (and more) about which you will have exam questions. Ethically, we cannot know exactly what will be on the exam you take. We can however, make sure you have a summary knowledge of the entire range of any possible question. It is then up to you to apply your knowledge to the questions asked in the exam.

If you find, in your studying, that you do not know very much about a subject, you will need to consult a text(s) on that subject which is more in depth than our summary. We do not pretend to give you a full course on any subject. If you find you don't understand or remember the broader material after reading our summary, look up (or find) other material to refresh your memory beyond what we can provide in this manual.

Since no one except the exam makers (and that doesn't include us) know exactly what is on the exam and what is not, we suggest you study all of the possibilities (all of the book). If you think that is over-kill—you are correct, but too much knowledge is considerably better than too little knowledge when it comes to preparing for a test and we believe you need to know all the material that might possibly be on the exam.

The Test Taking section includes simulations, scenarios and questions, and crossword puzzles to test your knowledge of the material. Some of you will find that your exam uses the multiple choice format and others of you will find the format on the exam you take will be different. We do not know which exam you are taking, but we do know that testing yourself in a variety of formats is a very good way to work with and assess what you know. We feel this section is valuable to everyone, even if your exam format is different.

We wish you well and we hope our study guide helps you to be successful in passing your test!

PART I

Content Areas

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Chapter 1 Growth and Development
Chapter 2 Personality and Social Development
Chapter 3 Assessment
Chapter 4 Diagnosis
Chapter 5 Treatment Planning
Chapter 6 Counseling Theories
Chapter 7 Treatment Modalities
Chapter 8 Special Treatment Issues
Chapter 9 Substance Abuse
Chapter 10 Psychopharmacology
Chapter 11 Research and Evaluation
Chapter 12 Statistics
Chapter 13 Outcome Studies
Chapter 14 Prevention
Chapter 15 Career Development
Chapter 16 Organizational Counsulting
Chapter 17 Professional Practice

CHAPTER 1

Growth and Development

HEREDITY VS. ENVIRONMENT

Heredity and Environment, the nature—nurture controversy has historically been one of the major issues in developmental psychology. Currently most theorists agree that development is neither entirely the result of either one's genes nor the environment. At the present time, discussion revolves around the relative contributions of these factors and the ways in which they interact.

1. Heredity

Heredity is not as well understood as environmental factors. It is difficult to separate the effects of each of these elements. Some heredity/genetic factors, however, are known to effect psychological growth and development. It figures in some major mental illnesses such as schizophrenia and mental retardation.

A. **PKU (Phenylketonuria),** which is caused by the presence of a single gene, is an inherited metabolic disease in which the body is unable to use the chemical phenylalanine. If this chemical accumulates in the body it can cause severe mental retardation unless controlled by diet.

B. **Tay-Sachs Disease** (caused by a recessive gene) is an inherited metabolic disorder occurring most often in Jews whose ancestry is a small area in Eastern Europe. This disorder causes increasing degeneration of the nervous system and the brain. Death usually occurs before the age of four years.

C. **Fragile X Syndrome** is an inherited disorder which causes a weakening or break on the X sex chromosome. This syndrome is the second most common identifiable cause of mental retardation in males (after Down syndrome). Males with this syndrome have long faces, big ears, and, as adults, large testes. Men, more than women, with this syndrome are likely to be severely retarded. Autistic behaviors and speech problems are also seen in people with this syndrome.

D. **Chromosomal Anomalies** are defects in the number or structure of chromosomes for example Down Syndrome and Turner's Syndrome.

1. **Down Syndrome** (Trisomy 21, Mongolism) is caused by the presence of an extra #21 Chromosome. Person's with this syndrome have a constellation of abnormalities such as retarded physical growth, flat face with short nose, protruding lower lip, small rounded ears, thickened tongue, broad hands and feet, stubby fingers, an increased susceptibility to illnesses, and lower than average IQ.
2. **Turner's Syndrome** affects only females. It results from the absence of an X chromosome. Some major characteristics of this syndrome are dwarfism, shield-shaped chest, infantile sexual development, webbed neck and lower than average IQ.

2. Environment

The environmental influences on development include both the physical and social domains.

A. Physical Domain

1. **The environment prior to birth** is very important. It is frequently the cause of below-average intellectual functioning. The causes include maternal infections, blood incompatibilities, chronic maternal conditions, chemicals in the fetal environment (i.e. alcohol, drugs), radiation, malnutrition, age of the parents and maternal stress (Sarason and Sarason, 1996).
2. **Difficulties at and after birth** include asphyxia and prematurity (birth three or more weeks before term - often low in birth weight - three lbs. or less). Damage to the central nervous system following birth may cause mental retardation. CNS damage include infections, blows to the head, tumors, asphyxiation, and poisons. Lead, arsenic, and mercury are the most common poisons leading to CNS damage (Sarason and Sarason, 1996).

B. Social Domain

Social influences can include the child's birth order, his/her role and experiences in the family, community, with peers, at school, the effects of his/her culture, society and interaction with his/her inherited characteristics.

SENSITIVE PERIODS

These are particular times in development when important learning is thought to occur, or is likely to occur. During these times a person is particularly sensitive to stimulation. In order to look more systematically at growth and development, including sensitive periods, organization principles have been developed by researchers. Some principles that help to organize our thinking about growth and development are the environmental-learning and the cognitive-structural orientations.

1. Environmental-Learning

The Environmental-Learning orientation "sees the child as passive, and malleable, heavily influenced (or formed) by the environment"..."(these) theorists prefer to regard development as a continuous process and to stress the continuities between animal and human, between child and adult"..."all knowledge derives from experience in the world: empiricism" (Gardner, 1978, pp. 17, 89). Major theorists: Ivan Pavlov, J. B. Watson, E. L. Thorndike, B. F. Skinner, Albert Bandura.

2. Cognitive-Structural

The Congnitive-Structural orientation holds that the child is an "active organism who constructs knowledge of the world"..."development consists of a set of discrete and highly distinctive stages"..."knowledge is acquired by constructive interaction between the human subject and the physical or social object: interactionism" (Gardner, 1978, p. 17, 89). Major theorists: Jean Piaget, Barbel Inhelder, Lawrence Kohlberg.

CLINICAL ISSUES

In order to make an accurate diagnosis and appropriately treat deviant or dysfunctional behavior it is important to:

1. Be knowledgeable about normal development

2. Consider appropriate age expectations

3. Be aware of the person's stage of development in the following areas:

A. Cognitive development

B. Emotional development

C. Personality development

D. Physical development

COGNITIVE DEVELOPMENT THEORIES

How do children come to know their world? We know there are differences in the way younger and older children get to know the world and that they solve cognitive problems differently. A number of approaches have been used to explain the variability in the cognitive processes of how learning takes place.

1. Environmental-Learning Theories

Environmental-Learning Theories hold that changes in thinking come from one's experience in the world. These theories emphasize the learning of specific associations between objects and events in the child's environment.

A. Classical and Operant (Instrumental) Conditioning

Classical conditioning was developed by Ivan Pavlov and is the linking of a stimulus with the response that is elicited (S-R). For infants, this begins with the reflex reactions which are linked to food. B. F. Skinner's Operant Conditioning (behaviorism) is based on an existing behavior (operant), which is then reinforced, allowing that behavior to be shaped. In the case of infants, the reinforcer may be imitating the child's verbalization. For older children, the reinforcer may be candy, a gold star, a special activity.

B. Social Learning Theory

As developed by Albert Bandura (1969, 1974), Social Learning Theory suggests that learning takes place by observing sequences of behaviors being engaged in by others (modeling) and later carrying out those behaviors that had been observed. In this theory it is believed that children do not form a separate response to all the observed behaviors, but represent to themselves a whole pattern of responses and their consequences. The child then attempts to reproduce the modeled behaviors. This theory is not applicable to infancy.

2. Cognitive-Structural

Cognitive-Structural theories see qualitative changes in thinking as resulting in cognitive growth. The Cognitive-Structuralist approach looks at structural or organizational changes in stages of thinking.

A. **Jean Piaget** is the best-known Cognitive-Structuralist. In Piaget's theory children learn by using their mental structures through adaptation and equilibration. Piaget considers the acquisition of knowledge to be deeply rooted in the biology of the organism. Acquiring knowledge is a continuous process, with assimilation and accommodation occurring perpetually, and schemes (mental structures) constantly changing. Piaget's basic tenants are:

1. **Assimilation** is the process of gaining new knowledge by absorbing it into existing schemes.

2. **Accommodation** is the process of gaining new knowledge by modifying an existing scheme to the new knowledge. Ex: A child attempts to understand new knowledge by using his/her current repertoire of cognitive schemes (assimilation). As the child begins to recognize that the information is new, he/she develops new ways of responding to the information (accommodation).

3. **Adaptation** is learning about the environment through cognitive growth using assimilation and accommodation.

4. **Equilibration** is the time when major break-throughs of understanding happen - when neither assimilation or accommodation dominates, but are in balance.

B. Piaget's Stages of Cognitive Development:

1. **Sensorimotor (Ages 0-2) The key accomplishment is object permanence.** The child perceives objects in the environment in terms of sensory information provided by the object and actions that can be performed on them. The child can differentiate self from others and can think of an object not actually present.

2. **Preoperational/Symbolic Thought (Ages 2-7) The key accomplishment is symbolic representation.** The child is able to use symbols (speech), and can engage in mental activities (operations), i.e., classify in more sophisticated ways, seriate, conserve, and can understand part-whole relationships or relational terms (e.g., bigger, lighter).

3. **Concrete Operational Thought (Ages 7-11) The key accomplishment is the knowledge that objects and states can be manipulated.** The child is capable of certain logic, can relate dimensions, can appreciate that some aspects of objects remain the same despite changes in appearance, and can classify elements into hierarchies.

4. **Formal Operations (Age 11) The Key accomplishment, reasoning, is based on verbal/logical statements.** The child can relate any element/statement to any other, can manipulate variables in scientific experiment, can deal with proportions and analogies, can construct whole systems of belief, can become actively engaged in the world of ideas, and can reflect on his her own activity of thinking.

C. **Jerome Bruner** emphasizes that enriched environments enhance children's learning and cognitive growth. Bruner's belief that language is the most important element in the development of logical thought differs from Piaget who believes that the most crucial element in logical thought is acquisition of operations. Headstart is based on Bruner's belief that enriched environments enhance children's learning and cognitive development. Bruner's Stages of Cognitive Development are:

1. **Enactive** (similar to Piaget's Sensorimotor Stage) The child interacts with the world, thereby learning from it. Interactions such as reflexive movements of sucking and kicking are learning events for the child.
2. **Iconic** (similar to Piaget's Preoperational Stage) learning is accomplished by using mental operations and images in the thought process.
3. **Symbolic** (similar to Piaget's Concrete and Formal Operational Stages) learning takes place through the use of symbols and logical operations.

OTHER FACTORS TO CONSIDER IN GROWTH AND DEVELOPMENT

1. Language Development

Language Development consists of learning the sound, order and meaning of language. **Phonemes** are the smallest units of sound (how language is composed.) **Syntax** is the way words are put together to form phrases, clauses, and sentences (the arrangements of words within an utterance and the relationship of utterances). **Semantics** is the relationship between the word and the environment (the meaning of any particular language). **Morphemes** are the smallest units of meaning ("bye", "up"). Gardner (1978, p. 175) describes normal language development:

A. **First Year -** babbling (approx. end of 1st yr. - "mama", "papa", "words" in isolation that appear to have meaning).

B. **Second Year -** holophrases-1 word ("doggie", "come"), duos (paired words).

C. **Third Year -** modulation of meaning (simple, appropriate sentences).

D. **Fourth Year -** correct, but noncomplex, language.

E. **Fifth Year -** language increasingly resembles adult models.

2. Effects of age and life span psychology

A. Intellectual Abilities that were learned mostly through education and experience in the world are believed to continue to improve into the 60's and beyond, for example, vocabulary, general information, and math skills. Abilities using skills such as abstract reasoning, conceptualization and attention may decrease after mid-life (Horn and Donaldson, 1980). Major decreases in intellectual abilities, however, are not generally found until the 70's (Kangas and Bradway, 1971). Lower test performance by older persons is often due to factors of sensory limitations, the person's own anxiety, tiredness, or not being interested in the test. The typical intellectual aging pattern is that the older person has higher verbal than performance scores. Researchers have found that intellectual performance drops significantly prior to death for all persons regardless of age (Riegel and Riegel, 1972).

B. During Mid-Life there may be some decrease in performance. Tasks needing coordination of eye-hand movements or speeded responses may decline during this time. However, for many people, creativity and productivity are often at their highest level in middle age (Turner & Pinkston, 1993).

C. After Mid-Life, other skills tend to decrease. Older adults may have difficulty in their long-term memory and speed of recall if the material to be recalled is not familiar to them or is irrelevant to their life. It has been found, however, that declines associated with aging can be reversed with appropriate training (Dennis, 1966).

3. Effects of gender

Effects of Gender - In Maccoby & Jacklin's (1974) review of the literature to that time, they found evidence of very few differences in cognitive development between males and females. There does, however, appear to be some differences beginning in the pre-adolescence years.

A. Females at age 10 to 11 scored higher than males on tests of verbal ability. It also may be that as adults, females continue to be more adept in verbal reasoning and word fluency (Schaie, LaBouvie, 1974).

B. Males scored higher than females on tests assessing visual-spatial skills, also about 10 or 11 years of age. A year or two later males began to score higher on math skills. As adults, males may continue to be more skillful doing tasks involving numbers and spatial relationships (Schaie, LaBouvie, 1974).

CHAPTER 2

Personality and Social Development

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THEORIES OF PERSONALITY DEVELOPMENT

1. Sigmund Freud

A. Theory of Psychosexual Development

Freud's theory holds that personality development is the result of interactions between biological drives. He believes that early social experience consists of three structures: id, ego, superego. He also posits a basic drive, the libido, which is the source of energy of all three personality structures. It operates under the pleasure principal which is the psychic force that motivates people to seek immediate gratification of instinctual (id) impulses.

1. The **id** is present at birth and represents a person's unconscious source of motives and drives. The id also operates according to the pleasure principle to reduce tension.

2. The **ego** is the part of the personality structure that emerges at approximately six months of age and represents logic and reason. The ego mediates between demands of the id, superego and reality and operates under the reality principle seeking to satisfy id urges in socially acceptable ways. Through the ego perception, memory, problem-solving and judgment develop.

3. The **superego** incorporates parental and societal values and standards into the personality, resulting in the conscience. The superego censures and modifies unacceptable id impulses. The superego develops between ages four and five because of the inability of the ego to reconcile the divergent demands of the id, superego and reality. This dynamic produces conflict and leads to a state of psychic distress or anxiety. The unresolved conflict provides the basis for future psychopathology.

B. Instinctual Drives

Freud developed a theory to explain how instinctual drives interact with childhood experiences producing adult personality. This theory of psychosexual development holds that a child's sex drive centers on a different part of the body during each stage of development. Personality results from the ways in which conflicts between id urges and social restrictions are resolved. The failure to resolve a psychosexual conflict or excessive satisfaction at any stage of development results in fixation at that stage and the beginning of future psychopathology. Fixation is defined as incomplete or inhibited development at one stage and the person stays at that stage until the conflict is resolved.

C. Freud's Stages of Psychosexual Development

1. **Oral** (0-12 mo.)
   Basic conflict - weaning
   Result of fixation - dependence, gullibility, sarcasm, orally-focused habits, i.e., passivity, smoking, nail-biting, and eating.

2. **Anal** (1-3 yrs.)
   Basic conflict - toilet training
   Result of fixation - anal retentiveness, stinginess, selfishness, obsessive-compulsive behavior, anal expulsiveness, cruelty, destructiveness, messiness.

3. **Phallic** (3-6 yrs.)
   Basic conflict - the Oedipus Complex (son attraction to mother), or the Electra Complex (daughter attraction to father)
   Result of fixation - phallic character and sexual exploitation of others
   Successful resolution - identification with the same-sex parent and development of the superego.

4. **Latency** (6-12 yrs.) (sexual drives & strivings are muted, unexpressed, or "latent")
   Basic conflict - social skills
   Successful resolution: greater ego function, once-dominant drives (ie: aggression) sublimated into athletic, social or intellectual activities.

5. **Genital** (12+ yrs.)
   Basic conflict - Focus on sexual issues i.e., sexual identity
   Successful resolution: less dependency on parents, new objects found for satisfaction of dependent & sexual needs.

D. Major Defense Mechanisms

Defense mechanisms are mental strategies that operate unconsciously and are used to reduce anxiety and emotional conflict arising from the differing demands of the id, superego and reality. They serve to deny or distort reality.

1. **Repression** - rejecting from conscious thought (denying or forgetting) an impulse or idea that provokes anxiety - reaction to instinctual stimuli. It is considered the most basic and most important defense mechanism, because it is the goal of all other defense mechanisms.

2. **Denial** - refusing to see something which is a fact or true in reality - reaction to external danger.

3. **Displacement** - substituting a different object or goal for an impulse or motive being expressed. (e.g., identifying through fantasy the expression of some impulse or motive).

4. **Reaction Formation** - expressing a motive or impulse in a way directly opposite than originally intended.

5. **Projection** - avoiding conflict within oneself by ascribing motives to someone else.

6. **Rationalization** - providing a reason for a behavior thus concealing the true motive for the behavior.

7. **Compensation** - attempting to develop or overdevelop a positive trait to make up for a perceived limitation.

8. **Identification** - identification with a person or cause with the unconscious hope that one will be seen as successful or worthwhile.

9. **Introjection** - accepting another's values as her/his own.

10. **Sublimation** - acting out an unacceptable impluse in a socially acceptable manner.

11. **Regression** - retreating to an earlier, safer, stage of development and behaving in ways characteristic of that stage in order to avoid anxiety.

2. Neo-Freudians

A. **Erik Erikson** borrowed from Freud, but differences remain. Erikson stressed the role of social rather than sexual factors in personality development. He believes that each stage of development is characterized by a psychosocial crisis representing the conflict between the individual and society. Erikson also sees personality development as a process that continues throughout the lifespan.

1. **Erickson's Stages of Psychosocial Development**

a. **Oral-Sensory** (0-12 mo.)
Major Conflict - Trust vs. Mistrust
Important Relationship - Primary Caretaker
Successful Outcome - Trust and optimism

b. **Muscular-Anal** (12-36 mo.)
Major Conflict - Autonomy vs. Shame and Doubt
Important Relationship - Parents
Successful Outcome - Self-assertion, self-control and feelings of adequacy

c. **Locomotor-Genital** (3-6 yrs.)
Major Conflict - Initiative vs. Guilt
Important Relationships - Family
Successful Outcome - Sense of initiative, purpose, and direction

d. **Latency** (6-12 yrs.)
Major Conflict - Industry vs. Inferiority

Important Relationships - School and Neighborhood
Successful Outcome - Productivity and competence in physical, intellectual and social skills

e. **Adolescence**
Major Conflict - Ego Identity vs. Role Confusion
Important Relationships - Peers and Leadership models
Successful Outcome - Integrated image of oneself as a unique person

f. **Early Adulthood**
Major Conflict - Intimacy vs. Isolation
Important Relationships - Partners in friendship and sex
Successful Outcome - Ability to form close personal relationships and make career commitments

g. **Middle Adulthood**
Major Conflict - Generativity vs. Stagnation
Important Relationships - Shared labor and household
Successful Outcome - Concern for future generations

h. **Maturity**
Major Conflict - Integrity vs. Despair
Important Relationships - Humankind
Successful Outcome - Sense of satisfaction with one's life and the ability to face death without despair

B. Adlerian Psychology (Alfred Adler)

Adler holds that all behavior occurs in a social context. He believes that transcending interpersonal interactions is the development of the feeling of being part of a larger whole. Adler views humans holistically as being: creative, responsible, "becoming" as a person and movfng toward fictional goals within the phenomenal field. He believes that a person's lifestyle is sometimes self-defeating because of inferiority feelings. A person with "psychopathology" is "discouraged", not "sick". The treatment task is to encourage the discouraged person to activate his/her social interest and to develop a new life-style through relationships, analysis and action methods.

C. Karen Horney

Horney broke with Freudian theory on the major issues of the influence of culture on the personality, the influence of "the here and now", and on feminine psychology.

1. **Influence of culture on personality and a focus on "the here and now".** Horney believes that neuroses are not generated by instinctual conflicts, but by specific cultural conditions which lead to disturbed human relationships. Freud believed anxiety was caused mainly by repression of sexual impulses. Horney's belief is that the frequency with which anxiety is generated by sexual impulses is largely dependent on the existing cultural attitude towards sexuality.

2. **Feminine Psychology.** Horney focused on feminine psychology, questioning Freud's belief that healthy women were biologically predestined to be submissive and masochistic. One of Horney's greatest contributions was in understanding women. She believed that women's behavior was the result of culturally enforced patterns. She held that the character structure of both women and men could be understood only as a product of cultural forces not as being genetically determined.

3. **Application of Horney's** theory in treatment is particularly useful in relieving women of psychological complications of culturally induced submissiveness, self-effacement and excessive dependency.

4. **The concept of the self is central to Horney's theory.**

   a. **actual self** - the sum total of the individual's experiences.
   b. **real self** - the central force or principle. It is unique within each individual and is equivalent to a sense of healthy integration or harmonious wholeness.
   c. **ideal self** - manifestation of neurosis. It serves as a means of avoiding psychic conflict by adopting an attitude of superiority or self-sufficiency or by demanding special consideration.

5. **Treatment emphasizes:**

   a. self-realization, self-actualization in dealing with the "here and now"
   b. activity of the analyst in the therapeutic process
   c. the emotional involvement between the therapist and patient as the most important aspect of the therapeutic process.

3. Carl Jung

Carl Jung studied with Freud, but later broke with him and elaborated his own theory of mental disorder called Analytical Psychology. The use of symbols is at the heart of Jung's theory. He believes symbols originate in the deep level of the unconscious, in the "objective psyche". These symbols are derived from the collective experience of the race - archetypal modes of thought. Jung believes that the realization of one's potential comes about through a gradual, laborious process of getting to know various facets of one's objective psyche. Many of Jung's concepts are part of psychiatric nomenclature and part of contemporary vocabulary:

A. **Archetypes** - a priori ordering principles for potential Gestalt, usually unconscious, but through the ages have given rise to similar forms of imagery.

B. **Extravert - Introvert** - the individual's source of energy is believed to be either the outer world of other people or the inner world of thoughts and ideas.

C. **Psychological types** - Categories of behavior based on our basic personality preferences. The Myers-Briggs Type Indicator uses Jungian theory.

D. **The Shadow** - the objective counterpart of the personal unconscious which represents some of the unacceptable aspects and components of the objective psyche.

E. **Anima and Animus** - combinations of personal and objective unconscious elements: anima - the feminine side of a man; animus - the masculine side of a woman.

F. **The Self** - at the very heart of the psyche; does not come into awareness until the person has succeeded in dealing with her or his Shadow and her or his anima or animus.

G. **The Persona** - official social mask or pattern of behavior that a person uses in social situations.

4. Object Relations Theory

Object Relations theory is seen as a reaction against the Freudian motivational concept of instinctual drives. Object Relations theorists believe that not only is "human behavior fueled by relational concerns, but also . . . the human psyche is fundamentally relational in nature" (Cashdan, 1988, p. 23). These theorists believe that in order "to understand what motivates people and how they view themselves, one needs to understand how relationships are internalized and how they become transformed into a sense of self" (Cashdan, 1988, p. 23).

"The term object relations refers to specific intrapsychic structures, to an aspect of ego organization, and not to external interpersonal relationships. However, these intrapsychic structures, the mental representations of self and other (the object), do become manifest in the interpersonal situation. That is, 'the inner world of object relations determines in a fundamental way the individual's relations with people in the external world'. The structural and dynamic relationships between the self-representation - the self - and the object-representations -the object- constitute what we refer to as object relations" (Horner, 1979, p. 3, 4).

The basic patterns between the self and the object (the first example is between child and major caregiver) evolve over the first three to four years of life and are the basis for ongoing mental configurations. In healthy development these intrapsychic structures continue throughout life, continually modified by experience. However, in pathological development they are organized in a rigid and distorted manner resulting in fixation at a pathological, infantile level of development in particular aspects of feeling, thinking, and behaving. The earlier the failure, the more pervasive and malignant the pathology. Certain kinds of disturbances are associated with developmental failure at certain stages or during transitional processes. With this developmental framework, one can understand both normal and pathological development, their consequences for adult character development and implications for the psychoanalytic treatment of the adult patient. Major Object Relations theorists are: Althea Horner, Otto Kernberg, Melaine Klein, W. R. D. Fairbairn, Margaret Mahler, Heinz Kohut, Blanck and Blanck.

5. Self-Actualization Theory

Abraham Maslow's theory of Self-Actualization holds the Ideal of Self-Actualization as the highest possible level of ego development. It is seen as the ability to use one's capacities to good purpose, to become fully absorbed in what one deems important and to do this in a lively, yet, selfless manner. Self-actualized persons are seen as fully human, capable of making choices. These persons choose to grow and are honest about their knowledge and limitations. They can accept responsibility and are willing to find out about themselves: who they are, what they like and dislike, what is good or bad for them, where they are going and what their mission in life is.

The special features characterizing the self-actualizer are:

A. **The Ability to Take Every Moment and Opportunity of Life Seriously** - to make the most of one's potential.

B. **The Capacity to Undergo Peak Experiences** - moments of ecstasy which are more likely to occur when one is honest with oneself, is willing to strive to realize one's potential, is capable of listening to others and when open for discovering what one is.

C. **Maslow's Hierarchy of Needs:** higher level needs come only when lower needs are largely satisfied, later in life (Bee, 1994):

Need for Self-Actualization

Esteem Needs
(Superiority and Respect, Including Self-respect)

Love and Belongingness Needs
(Affection from Others, Need to be with Others Rather than Alone)

Safety Needs
(Stable, Predictable Environment, Free From Anxiety and Chaos)

Physiological Needs
(Hunger, Thirst, Sex, Oxygen, Sleep, Elimination)

(Source: Maslow, 1968)

MORAL DEVELOPMENT

1. Lawrence Kohlberg

Lawrence Kohlberg was influenced by Piaget's concept of developmental stages. Kohlberg's theory holds that moral judgments are developed in sequences that cannot be changed. Each stage arises from the previous one and each is cognitively more complex than the previous stage. The levels and stages relate to the self and society.

Levels of morality:

Level 1 - Preconventional (4-10 yrs.)

In Stage 1, the orientation is on punishment-obedience. Moral judgment is based on the desire to avoid punishment.

In Stage 2, the orientation is on instrumental-relativism. Moral judgment is based on the desire to satisfy one's own needs and obtain rewards.

Level 2 - Conventional (10 - 13 yrs.)

In Stage 3, the orientation is on being "the good child". Moral judgment is based on the desire to avoid disapproval, to avoid the dislike of others, and secure interpersonal acceptance.

In Stage 4, the orientation is on law and order. Moral judgment is based on the desire to avoid censure by the legitimate authority.

Level 3 - Postconventional (adolescence - adulthood)

In Stage 5, the orientation is legalistic. Moral judgment is based on maintaining respect of others in the community, maintaining social order and valuing social contracts.

In Stage 6, the orientation is on universal ethical principles. Moral judgment is made within one's own conscience.

2. Carol Gilligan

Carol Gilligan worked with Kohlberg, later developing her own theory of moral development for females. She says that Kohlberg largely ignores an ethical/moral system based on caring for others, responsibility, altruism or compassion which includes more of the female's moral development. Instead, he focuses almost exclusively on the development of concepts of justice or fairness, more typical of males, not concepts of care. (Kohlberg's research population was exclusively male.) Gilligan maintains that women view relationships differently than men. Later research has shown that girls and women do use moral reasoning based on principles of justice when they are presented with dilemmas in which that is a central issue. Gilligan includes a much broader range of ethical stances than Kohlberg suggests.

OTHER ISSUES IN PERSONALITY AND SOCIAL DEVELOPMENT

1. Attachment

Attachment is the primary bond developed between an infant and primary caretaker. Particular behaviors maintain or increase the proximity between an infant and another person, for example: signaling behaviors (smiling, vocalizing), orienting behaviors, locomotion, active physical contact (clinging, hugging). Attachment is essential for infants.

A. **In Harlow's** (1958) research he found that monkeys reared in total isolation developed repetitious behaviors of rocking, self-clasping, lack of exploration, and other behaviors not much different from human schizophrenics. Monkeys raised with surrogate mothers were found to be less abnormal, but problems were evident. They had difficulties in establishing peer relationships, in participating in normal sexual activity, and in parenting their own offspring. Later research has found the negative effects of isolation and surrogate mothering can be, at least partially, reversed.

B. **Konrad Lorenz** (1937), in his work with imprinting found that ducklings follow the first object they see. He believed it was an adaptive function that keeps the young close to the mothers. He found a stronger bond with: 1. a stimulus that was large and moving 2. a stimulus that responded to the infant duckling with sound.

C. **John Bowlby** (1958), another major attachment theorist, emphasized the adaptive function of attachment: 1. closeness to food, 2. protection from predators, 3. opportunity for socialization. He proposed that human infants have behavioral systems ensuring development of attachment which increase the chances for survival, such as: sucking, crying, smiling, vocalizing, crawling, walking. If early attachment fails, there may be an inability to develop close social relationships. Bowlby also discussed the concept of separation.

1. **Bowlby's stages of attachment development:**

   a. Undiscriminating Social Responsiveness (0-3 months) Behaviors include: attachment behaviors, orienting behaviors (visual fixation), contact-promoting behaviors (grasping, smiling, crying).

   b. Discriminating Social Responsiveness-(3-6 months) Behaviors include: distinguishing between family and non-family by differential smiling, crying, vocalizing.

c. Active Initiative in Seeking Proximity and Contact (6-30 months) Behaviors include: active proximity and contact-promoting behaviors of following and greeting.

d. Correct Partnership (30+ months) Behaviors include: predicting caretaker's behavior, developing methods for shaping caretaker's behavior toward the goal of developing attachment.

2. Concepts related to separation:

a. **Stranger Anxiety -** begins at approximately 8 months. Behaviors include crying, withdrawal and other fearful responses to strangers. These behaviors occur when the child has developed object permanence (is able to keep the caretaker in mind). When the caretaker is not present the child recognizes the difference between the known and the unknown which produces anxiety.

b. **Separation Anxiety -** begins at approximately 12 months. Fearful responses are displayed when the child is left by the caretaker. The appearance of these behaviors is related to the intensity of the child-caretaker attachment. It is part of normal development. In prolonged separation, Bowlby (1973) suggests that the child begins to adapt to the loss in progressive stages:

- Protest - child refuses to accept the separation by crying, screaming, kicking.
- Despair - child gives up all hope of being reunited and becomes quiet, inactive and withdrawn.
- Detachment - child begins to accept attention from others, recovers from her/his state of misery and may react with detachment and disinterest when visited by former caretakers.

c. **Anaclitic Depression -** Spitz (1946) found that institutionalized infants separated from their mothers in the first year of life and receiving minimal social contact developed "hospitalizms": retarded growth, poor physical health, high susceptibility to disease, and deficits in motor and cognitive development. Infants separated from their mothers for at least three months also displayed anaclitic depression. They evidenced listlessness, crying and withdrawal. The effects of institutionalization, however, could be reversed with consistent and frequent personal attention from substitute caretakers.

d. **Infantile Autism -** Children with infantile autism often do not have attachment behaviors such as eye contact, reaching, and smiling. They rarely initiate contact with caregivers and appear oblivious to others. They later fail to develop normal interpersonal relationships. The cause is not seen as parental deprivation, but one of heredity where certain physiological conditions pertain. (Knobloch & Pasamanick, 1974).

2. Sex Role Development

Sex Role Development (Sex Typing): The relationship between personality, behavior and gender. Approaches from the different theoretical orientations:

A. Biological

Factors in sex-role behaviors are unclear. Some theorists believe some sex differences appear before the environment has had a chance to make a difference. Examples include: newborn boys generally are more active than newborn girls - they cry more and sleep less (Maccoby & Jacklin, 1974). Sex-role differences may also be due to hormonal differences where the Y (male) chromosome creates more androgen in the brain during prenatal development.

B. Psychoanalytic

Freudian Theory. Gender-role identification comes from the Oedipus and Electra conflicts in the phallic stage of development (between 3 and 6 years of age). The child sees her/himself as a rival of the same-sex parent. Anxiety develops when the child recognizes the desire for the opposite sex parent won't be fulfilled. To reduce the anxiety, the child identifies with the same-sex parent and adopts that parent's behavior.

C. Social Learning

The development of appropriate sex-role behaviors is the result of gradual learning, beginning during infancy. The child's behavior is shaped by parents and others selectively rewarding and punishing appropriate or inappropriate behaviors of the same-sex parents and older siblings whom the child imitates.

D. Cognitive

The development of sex-role behaviors involves a sequence of stages dependent on the child's level of cognitive competence. By age two or three the child acquires gender identity, can label self as female or male and exhibits sex type toy preferences. By age four gender stability is established where the child knows a person remains female or male throughout life. By age six or seven the child has established gender consistency, knowing that sex is a permanent state that cannot be changed by changing appearance such as changing clothing. Sex-typed behavior is acquired by imitating same-sex models.

3. Family factors related to personality and social development

A. **Parenting Styles** play a role in a child's personality development. The interaction of permissiveness and affection on the part of the parents affects personality development (Schaefer, 1959):

1. **Love and Autonomy -** parents are loving and accepting - children tend to be independent, outgoing, active, assertive, tolerant, high in self-esteem.
2. **Love and Control -** parents are high in both affection and control - children tend to be dependent, insecure and low in creativity.
3. **Hostility and Autonomy -** parents are hostile and noncontrolling - children tend to be disobedient, aggressive, and rebellious.
4. **Hostility and Control -** parents are hostile and controlling - the children tend to be socially withdrawn, sullen, shy, and self-punishing (Baumrind, 1971).

B. **Birth Order -** first-borns (and only children) may be treated differently receiving more maternal attention and stimulation, and greater achievement orientation. This attention and stimulation may contribute to higher IQ scores for these children than later-born children.

C. **Peer Factors** become more formal and structured after about age 10, when the child's status in the peer group is more important. Popular children tend to be the youngest, rather than the oldest and to be more attractive, intelligent, and creative. They may have higher levels of self-control, self-confidence, mature dependence on other children and to have good social skills. Girls often focus on intimacy and shared feelings while boys focus on shared activities. Peer influence is greater in the areas of selection of friends, fashion, music and language fads. Parental attitudes continue to influence adolescents in moral and social values, future aspirations and political views.

4. Age Factors—The study of how changing priorities and experiences of age affect personality

A. Daniel Levinson Identified Major Transitions in Adult Life:

1. Early adult transition (ages 17-22)
2. Mid-life transition (ages 40-45)
3. Late adult transition (ages 60-65)

B. Levinson Postulates That There Are Three Developmental Tasks of Adulthood

1. To build, modify, and enhance one's life structure
2. To form and modify single components of the life structure, for example: life dream, occupation, love-marriage, family relationships, mentoring, forming mutual relationships
3. To become more individuated

C. Stages of Adulthood as Seen by Other Theorists:

1. **Early adulthood** (in the 20's) is seen by some theorists as being a time of looking outward to establish one's career, to marry or make life partnerships and to begin a family. Decisions made in one's 20's may become a source of conflict because of later re-evaluation of earlier decisions. The second half of early adulthood (28-34) may contain difficult transitions, i.e., end of partnership/marriage, change in career.

2. **Middle adulthood** may include mid-life transitions ("mid-life crisis") (Levinson, 1978). Between ages 35 and 45 may be a time of evaluation of the discrepancy between one's accomplishments and one's life goals. A person may experience a confrontation with personal limitations, with acceptance.of the inevitability of aging and death as well as re-formation and re-prioritization of goals to be more consistent with reality.

3. **Late adulthood** studies on "successful aging" have found generally inconsistent results. Some agreement has been found where successful adjustment is related to a person's previous level of adjustment. Satisfaction has also been associated with self-esteem, financial resources, marital status and health. Personality has generally been found to remain stable into old age. Some characteristics have been found to be age-related. Introversion and cautiousness tend to increase during the second half of life. The major task of late adulthood is seen to be retirement; the primary factors of which are health and financial resources. Continued participation in pre-retirement activities (or substitute activities) is seen to be associated with successful retirement.

4. The most significant task of **Old Age** is facing death, one's own, the death of spouse/partner, family members and friends. Kubler-Ross believes that most dying patients pass through the stages of denial, anger, bargaining, depression and finally acceptance of death. Personal reactions to dying are affected by whether one is living in familiar and stable surroundings, in which case one is often less afraid of dying. Persons about to be admitted to a "home for the aged" are more afraid of dying. Elderly persons are generally less anxious about death than middle-aged people.

CHAPTER 3

Assessment

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The term's assessment, appraisal and testing are often used to describe the same activity. For the needs of this chapter, they will all refer to the same process unless specified otherwise. Anastasi (1988) describes psychological testing as "an objective and standardized measure of a sample of behavior." Earlier forms of assessment were simply the clinical interview which included the patient's history and their current situation. Tests were developed to counter the subjectivity and variability of interview techniques. Current assessment takes many forms. Assessment can be diagnostic specific (Beck Depression Inventory) a structured interview or a complete neuropsychological battery. It is the job of the clinician to determine what is appropriate for each client.

THE ROLE OF THE CLINICIAN

Clinicians use a wide range of information to make decisions during their work. The assessment process begins with the first contact of the potential client. An assessment is made of the content as well as the process of the interactions. Formalized tests are one method of gathering information, and the scores that are generated are vehicles for creating hypotheses. Clinicians need to be aware of test construction, statistics and test interpretation. "The clinician should use all the objective test data and actuarial strategies applicable to the particular situation, while supplementing this information with facts and inferences attainable only through clinical methods", (Anastasi, 1988). Mental health counselors can administer and interpret any test they have had the education and experience needed to qualify them, unless the region in which they have practiced has current laws or legislation that prohibits their test administration.

1. Clinical judgment

A. Gathering Information

The development of rapport with the client increases the likelihood that accurate and honest information will be gathered. The clinician must also be aware of their responses to the client as information is obtained. Bias can enter into this dialogue from many different areas such as the clinician's theoretical

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beliefs and personal life experiences. The more unstructured the testing is, the higher the possibility of bias entering the assessment outcome.

B. Interpreting the Data

The test outcome should be integrated into the whole picture of the client including etiology, systems of interaction, treatment recommendations and prognosis. Using the test outcomes the clinician can redefine the hypothesis about the client, the diagnosis, treatment plan and interventions or future prognosis.

2. The ethics of assessment

Clinicians must abide by the ethical standards of their professional association. Every counselor must also abide by the national and regional laws and legislation that relates to testing. A practicing clinician must maintain current accurate information pertaining to the ethics of assessment and abide by it. Ethical standards cover and are not limited to:

- Privacy and confidentiality
- Competencies required to administer tests
- Interpretation of test results
- Communicating test results
- Norms
- Validity
- Reliability
- Requiring that testing materials not be made available to the general public to ensure continued test validity

3. Test settings

Testing can be done in a number of settings. The following are examples and are not the only places assessment can be done:

- Clinician's office
- Client's home
- Referring professional's office
- Physician's office
- Hospital
- School
- Work
- Jail
- Clinic

The appropriateness of the setting and its impact on the test scores must always be considered.

4. Selecting tests

The first question must be how useful will this test be in answering a clinical question. The second question must be how qualified am I in administering this test. Also to be considered is the time needed in administration and cost. Testing appropriateness for the client must be considered. Will this test lead to other tests? How much can the client tolerate the testing process? Finally, do you have the clinical expertise to make all of these decisions or do you need professional consultation before making any decisions? Test resources are listed in:

- *The Mental Measurements Yearbook* (Kramer and Conoley, 1992)
- *Tests: A Comprehensive Reference for Assessment in Psychology, Education, and Business* (Sweetland and Keyser, 1991)
- *Measuring Mental Illness: Psychometric Assessment for Clinicians* (Wetzler, 1989)
- *Measures for Clinical Practice: A Sourcebook* (Corcoran & Fischer, 1994)
- *Tests in Print IV* (Buros, 1994)

A. Evaluating a Psychological Test

Before administering or referring a client for testing, the clinician must evaluate the appropriateness of the test. The following questions need to be considered (Groth-Marnat, 1997):

- Do I understand the theoretical construct the test is supposed to be measuring?
- Do the test items correspond to the theoretical description of the construct?
- Does the examinee's ability to read and understand match the level required by the test?
- How appropriate is the length of the test?
- Is the person/population to be tested similar to the population the test was standardized for?
- Was the standardization size sample adequate?
- Have specialized subgroup norms been developed?
- How adequately do the instructions permit standardized administration?
- Are reliability estimates high enough?
- What criteria and procedures were used to validate the test?
- Will the test produce accurate measurements within the context and purpose for which I would like to use it?

B. Psychological Assessment and Treatment Planning

Assessments are used to gather information to facilitate clinical decision making. The assessment outcomes must be integrated into the whole picture, sometimes referred to as case management, which includes but is not limited to the following:

- Developmental approaches
- Assessment tools designed to identify targeted diagnosis i.e., phobia, depression
- Refining intervention techniques based on assessment outcomes i.e., the extent of vegetative or manic symptoms
- Identifying what kind of therapy to use with a client
- Tailoring interventions around the stages of change; precontemplation, contemplation, preparation, action and maintenance

C. Treatment planning needs to consider:

1. The severity of the problem which can be measured with:
    - MMPI (Minnesota Multiphasic Personality Inventory)
    - Mental Status
    - DSM-IV Multiaxial Assessment

2. The level of motivation of the client
   - MMPI
   - BSI (Brief Symptom Inventory)

3. How complex the problem is
   - Number of DSM diagnoses
   - Pervasive or recurrent problem patterns

4. Pervasive personality disorder
   - MMPI
   - TAT (Thematic Apperception Test)

5. The level of client resistance to treatment
   - MMPI
   - MCMI (Millon Clinical Multiaxial Inventory)

6. The extent of the client's coping mechanisms and styles
   - MMPI
   - MCMI

7. The level of development in the change process
   - Stages of Change Scale

TYPES OF TESTS

Objective tests are usually true/false or multiple choice. They tend to have higher reliability than projective tests since their scoring is not subjective, or based on the opinion of the reviewer. Subjective, or projective tests, are usually essay, short answer tests. Answers are created as a result of exposure to a particular stimulus. Test administrators who use projective techniques, require administration and scoring training. Projective tests are thought to have lower reliability. What all of these tests seem to have in common is that they measure a sample of behavior/s, and they have a standardized procedure for gathering information and analyzing it.

A criticism of the use of tests in counseling focuses on the administration and interpretation process. Although the administration is usually well documented in the test manual, often there is a lack of instruction to the test provider on how to adequately interpret the results. It is generally found, that a cursory interpretation is provided with the test materials. There are many objective tests that can be given by a clinician and computer scored with an interpretive analysis of the data. However, the responsibility lies with the tester to understand the appropriateness and interpretability of the test being given, and how helpfully it is presented to the client.

1. The assessment interview and case history

"There are two interview styles used by mental health professionals: insight oriented (psycho-dynamic) and symptom-oriented (descriptive)" (Othmer & Othmer, 1994).

A. Insight Oriented

Based on the work of Sigmund Freud, the insight oriented belief is based on the experiences of the past unconsciously interfering with the client's current symptoms and pain. The goal of the insight oriented interview is to uncover these conflicts, bringing them into awareness. The role of the clinician is to not only help uncover these pathogens, but to help interpret their meaning. The interview serves a dual purpose of diagnosis and therapy. The key word for this methodology is "explains."

B. Symptom Oriented

Related to the DSM, this interview style clusters symptoms and behaviors into the clinical criteria required for a DSM diagnosis. Other information included is the client's coping skills, medical condition, stressors, psychosocial and environmental problems. The keyword for this methodology is "classifies."

C. Phases of the Interview

Phase 1 - Establishing Rapport

- Put the client at ease
- Find out where they are experiencing pain and show compassion
- Assess their ability to have insight
- Establish yourself as an expert
- Lead the interview
- Vary the role as needed by the client i.e., listener, expert, empathizer
- Insight oriented - transference and countertransference patterns are noted as the interview proceeds
- Symptom oriented - As trust is established more information will be brought forward

Phase 2 - Interview Techniques

- Insight oriented - Techniques used can be free association, confrontation and interpretation
- Symptom oriented - The focus is on signs, behaviors, objective and measurable symptoms

Phase 3 - Mental Status Assessment (MSA) The mental status examination is the primary intake assessment method used in many mental health settings. It is an assessment that is used by many clinicians when they first meet a client. The MSA is used to create a global view of the functioning of the client. The MSA has been called the psychiatrist's analog to the general physical examination. It is often used in an initial psychological report and as a global measure for outcomes. The MSA is available in both non standardized, more subjective and standardized, check-list types of formats. The MSA is an important assessment tool to become familiar with since it is well known across the profession and is often used when case material is presented by colleagues. A sample MSA follows this chapter.

Phase 4 - Diagnosis (DSM)

- Assessment of Axis I disorders
- Assessment of Axis II disorders
- Diagnostic focused interview models (Groth-Marnat, 1997)
- Anxiety Disorders Interview Schedule (ADIS)
- Diagnostic Interview for Borderlines (DIB)
- Psychopathy Checklist (PCL)
- Structured Interview for DSM-IV
- Dissociative Disorders (SCID-D)
- Structured Interview of Reported Symptoms (SIRS)
- Psychosocial Pain Inventory (PSPI)
- Comprehensive Drinker Profile (CDP)
- Eating Disorder Examination (EDE)

- Eating Disorder Inventory-2 (EDI-2)
- Structured Interview of Sleep Disorders (SISD)
- Substance Use Disorders Diagnostic Schedule (SUDDS)
- Schedule for Affective Disorders and Schizophrenia (SADS) - Adult version and Child version
- Diagnostic Interview Schedule (DIS) - Child version (DISC)

Phase 5 - Multiperspective evaluation

a. History of the Problem
  - Description - intensity and duration
  - Date of onset
  - Changes
  - Previous diagnoses and protocols
  - Antecedents and consequences

b. Family Background
  - Socioeconomic level
  - Cultural environment and background
  - Parent's occupations and current health
  - Emotional history
  - Medical history
  - Relationships between family members (single, married, separated, divorced, widowed, affective dynamic)

c. Developmental Personal History
  - Infancy
    - Birthing abnormalities
    - Parents' emotional state
  - Early and middle childhood
    - School
    - Peers
    - Interests
  - Adolescence
    - Dating
    - Acting out
    - Puberty
  - Early and middle adulthood
    - Career/occupational system
    - Relationships
    - Life goals
  - Late Adulthood
    - Reaction to changing abilities
    - Economics

d. During any phase
  - Traumas
  - Losses
  - Medical problems
  - Fears
  - Self-esteem
  - Economics
  - Relationships

ABILITY TESTING

1. Intelligence

There does not appear to be a consensus in the field about the definition of intelligence. Some of the offerings are:

- Global mental capacity
- Several separate factors
- General mental ability
- General intellectual factor
- Primary mental abilities
- Verbal-educational and spatial-motor factors
- Expression of an individual's ability level at a given time, in relation to the available age norms (Anastasi, 1988)
- Information measured by an intelligence test

A. Stanford-Binet Intelligence Scale

Developed in 1905 by Alfred Binet and Theodore Simon at the request of the French Minister of Public Education to identify retarded children, this test is probably the best known measure of intelligence in the public arena. The current test has been revised many times. The Fourth Edition was published in 1986 and has been changed both in structure and content. This edition is used for individuals aged 2 through adult.

Administration and Scoring

The test is given by an individual examiner to an individual examinee. The test portions given are chosen for appropriateness to their developmental level. The test provides the examiner with guidelines on how to determine this factor. Raw test scores are converted to Standard Age Scores according to the conversion tables in the test manual. A standard deviation of 8 is built into individual area scores (i.e., cognitive ability) and a standard deviation of 16 is built into the test composite.

B. Wechsler Tests - WAIS-R, WISC-R, WPPSI

First developed and published by David Wechsler in 1939 as a tool to assess intellectual ability of older adolescents and adults. Since then, other scales have been designed:

WAIS-R-(Wechsler Adult Intelligence Scale-Revised Edition)	ages 16 - 74
WISC-R-(Wechsler Intelligence Scale for Children-Revised Edition)	ages 6-16
WPPSI-(Wechsler Preschool and Primary Scale of Intelligence)	ages 4 - 6 1/2

The Wechsler tests reflect its authors view of intelligence as a global capacity with several interrelated functions. There are eleven subtests to the WAIS-R. All three tests indicate individual subtest scores as well as Verbal, Performance, and Full Scale deviation IQ scores.

Administration and Scoring

This test is administered much like the Stanford-Binet. The test alternates between verbal and performance subtests. Raw subtest scores are converted to standard scores with a mean of 10 and a standard deviation of 3. Subtest scores are summed and converted to deviation IQ's using conversion tables in the test manual.

C. Child, Infant and Preschool Tests

Developmental performance tests are usually used with this age population. Due to the short attention span and low test-taking tolerance these tests are difficult to administer and have lower levels of reliability than measures of intelligence in older children and adults. There is also the issue of the changing definition of intelligence at this age.

Some tests for this population are:

Bayley Scales of Infant Development
Brazelton Neonatal Assessment Scale
Cattell Infant Intelligence Scale
Gessell Developmental Schedule
Kaufman Assessment Battery
McCarthy Scales of Children's Abilities
Piagetian Scales

D. Tests for the Mentally Retarded

According to the American Association on Mental Deficiency (AAMD), mental retardation cannot be diagnosed on the basis of IQ test scores alone, they can only be diagnosed when low IQ is accompanied by deficits in the ability to cope with the demands of daily life. Since this area of assessment is particularly sensitive because of mandated treatment, educational laws and legislation, there are other criteria for testing this population.

Some tests often used are:

Adaptive Behavior Scale
Bruininks-Oseretsky Test of Motor Proficiency
Vineland Adaptive Behavior Scale

E. Tests for the Physically Handicapped

Tests often used to assess the general intellectual ability of hearing-impaired individuals, blind individuals, and individuals with orthopedic handicaps, are described below. There are also other tests that have been adapted for use with the handicapped, for example, the Stanford-Binet, Wechsler, SAT and Vineland are available for visually impaired examinees. Other tests include:

Arthur Point Scale or Performance Tests (Hearing loss)
Columbia Mental Maturity Scale (Orthopedic handicaps)
Haptic Intelligence Scale for the Blind (Blind)
Hiskey-Nebraska Test of Learning Ability (Hearing loss)
Peabody Picture Vocabulary Test - Revised (Orthopedic handicaps)
Porteus Maze Test

F. Cross-Cultural or Culture Fair Tests

As our culture becomes more ethnically diverse there is a growing need for tests that are "culture-fair." These tests are based on the assumption that cultures differ in language and in terms of the value they place on rapid performance, family, objects and information. Tests that meet these criteria are:

Black Intelligence Test of Cultural Homogeneity
Leiter International Performance Scale-Revised
Goodenough-Harris Drawing Test
IPAT Culture Fair Intelligence Test
Raven's Progressive Matrices
Test of Nonverbal Intelligence

G. Intelligence Tests for Industry

Industry long ago discovered they were ahead of the game if their employees had cognitive skills, job related knowledge, the ability to solve problems and interpersonal skills. Given this information, the employer can choose the best person for the required task or set of tasks.
Some measures that are used are:

Otis Self-Administered Test of Mental Ability
Personnel Tests for Industry
Wonderlic Personnel Test

H. Group Intelligence Tests

These tests are used in schools, industry and the armed services, or in any setting where large numbers of people are being examined. They are generally made up of multiple choice questions and administered in a large group setting. Their advantage is obvious, a large number of people are tested in less time. Their disadvantage includes the lack of ability to respond to the individual's needs, and the administrator not being able to observe test-taking behaviors. Group intelligence tests are considered to evaluate a more limited range of cognitive abilities than individual tests. One test most of us are familiar with is the SCAT (School and College Ability Tests) which is used to test academic achievement. Other tests include:

Cognitive Abilities Tests
Henmon-Nelson Tests of Mental Ability
Kuhlmann-Anderson Tests of Mental Ability
Multidimensional Aptitude Battery
Otis-Lennon School Ability Test

2. Computerized Adaptive Testing (CAT)

Computerized testing can adapt to the individual's responses and can stop testing when the individual's answers have provided enough information about their content mastery. They are used in educational, industrial and military settings.

PERSONALITY

Personality tests are used to "identify emotional, motivational, interpersonal and attitudinal characteristics," (Anastasi, 1988). It is believed these pull together and identify which "personality type" you are. The two major approaches to measuring personality are through a self-report inventory or a projective test. Some of the best known are:

1. Inventories

A. Minnesota Multiphasic Personality Inventory (MMPI)

The MMPI was created for use with people 16 years or older. It is made up of over 500 items (16 duplicated), that represent different scales of measurement. Questions include items such as: "I do not tire easily," "I am happy most of the time." The MMPI is a very widely used personality inventory. It reports against three validity scales (L, K, and F), and 10 clinical scales (Butcher & Williams, 1988).

1. Validity Scales

Validity scales are intended to measure the validity of the test scores. They consist of:

L - Lie scale, consists of 15 items that make an examinee appear in a favorable light. People who score high on this scale are presenting themselves in an excessively "pure" manner. High scores are represented by many false responses.

F - Measures consistency and is composed of 64 items that are rarely responded to in the scoreable direction. A high F score may result from extreme eccentricity, idiosyncrasy, psychiatric illness, response carelessness or scoring errors.

K - Suppresser variable, is made up of 30 items designed to assess the examinees need to present in a favorable light (high K) or attest to many personal defects or weaknesses (low K). K scores are used to compute a correction factor which is added to certain clinical scale scores to obtain adjustment scores.

2. Clinical Scales

Clinical scales measure specific clinical diagnosis. They include:

HS	Hypochondrias - concern with body symptoms
D	Depression - pessimism, hopelessness
HY	Hysteria - uses symptoms to solve problems
Pd	Psychopathic deviance - disregard for social standards
MF	Masculinity/Femininity - interests like those of the other sex
Pa	Paranoia
PT	Psychasthenia - worried, guilt feelings
Sc	Schizophrenia - withdrawn, bizarre thoughts
Ma	Hypomania - overactive, excited, impulsive
Si	Social Introversion - shy, inhibited

The MMPI can be very accurately computer scored

B. California Psychological Inventory (CPI)

The CPI can be used with ages 14 to adult. It's used in many environments including business, academic, military and counseling. It identifies potential leadership qualities, predicts achievement orientation, and selects and develops employees to ensure the best possible person for a job. The responses provide a profile on three major vectors:

- **First** Client's interpersonal orientations, internality to externality
- **Second** Normative orientation with peers
- **Third** Sense of fulfillment.

C. Myers-Briggs Type Indicator (MBTI)

This instrument was developed in the 1920's by Katherine Briggs and her daughter Isabel Myers. It is a self-report instrument that identifies preferences for taking in information, making decisions and identifying a preference for an outer orientation toward action, people, or things, or an inner orientation toward ideas, concepts, and abstractions. The MBTI is used extensively in industry and by the military to match individuals to tasks and problem solving situations.

You will use the MBTI to help identify your best study method for this test.

D. Sixteen Personality Factor Questionnaire (16 PF)

In 1949 Raymond Cattell published the first edition of the 16 PF - the 16 Personality Factor Questionnaire. It was proposed to measure the whole of human personality using a structure discovered through factor analysis. This measure can be used in counseling settings as well as in career, business and industry. It helps in personnel selection and development. It identifies personal qualities that influence work-setting behaviors such as problem-solving style and interpersonal style. Scales included are: problem solving, stress, interpersonal relationships, work organization and environment, career interests and personal growth. Norms have been taken from high school, college and adult populations. This test can be computer scored with a variety of reports and narratives (Butcher, 1989).

E. Other Personality Assessments Include:

Edward's Personal Preference Schedule (EPPS)
Leary's Interpersonal Check List (ICL)
Millon Clinical Multiaxial Inventory (MCMI)
Schutz FIRO - B

2. Specialized

A. Bender Gestalt Test - Brain Dysfunction

A classic measure of visual-motor integration, the Bender Visual Motor Gestalt Test is designed to screen for brain dysfunction. The test consists of nine stimulus cards, each showing a figure. The client is asked to reproduce the figures, a task requiring visual association, motor coordination, and the ability to integrate the perceptual with the motor to achieve accurate reproduction of the stimulus.

B. Luria Nebraska Neurophsychological Battery

The Luria-Nebraska consists of 269 items selected on the basis of their importance in diagnosis. Each item represents an important aspect of the following 11 skill areas: motor functions, rhythm, tactile functions, visual functions, receptive speech, expressive speech, reading, writing, arithmetic, memory and intellectual processes. Raw scores for each item can be converted to scaled scores from 0 to 2, with a score of 0 suggesting that the examinee is functioning within the normal range and a score of 2 suggesting brain injury.

PROJECTIVE TESTS

Projective tests are based on the assumption that the individual reveals his/her personality through responses to the test stimuli. The projective test is relatively unstructured with few demands or tasks. The examiner is asked to interpret or structure his/her request as well as his/her responses. A major criticism of projective tests is that interpretation is based on the test provider's beliefs, perceptions and subsequent evaluations.

Projective instruments include a camouflaged testing procedure. The individual usually has no idea of what the examiner is looking for. The projective instrument is thought to assess the whole person including intellectual processes, conflicts, needs and emotional responsiveness, thus, completing a picture of the personality. It is believed that the projective techniques access latent or unconscious processes.

These tests are quantified. Scores or numbers are interpreted around some criterion or group norm. This gives the examiner a statistical idea of how the individual compares with others who had similar responses.

1. Classifications of projective test are:

Association Techniques - the individual is presented with a stimulus and responds with a word or precept, i.e., Rorschach and Word Association Tests

Construction Technique - a complex set of processes by which the individual develops a response to a given stimulus situation, i.e., Thematic Apperception Test

Completion Techniques - the person is asked to complete some stimulus or task, i.e., Sentence Completion

Choice Or Ordering Techniques - the person is asked to choose from a number of alternatives or stimuli's presented, i.e., Values Assessment

Expressive Techniques - a variety of procedures such as drawing, painting, and psychodrama that can simultaneously be methods of assessment and treatment, i.e., Draw A Person Test (Maloney, 1991)

2. Types of projective tests:

A. Rorschach

Henry Rorschach, a Swiss psychiatrist, published *Psychodiagnostics* in 1921, in which he presented a technique for assessing an individual's "whole" personality by the manner in which he responded to a number of inkblots. The test is composed of ten plates or cards on which bilaterally symmetrical inkblots have been printed. The subject is told they will be shown a number of inkblots and is asked to report what they may look like or what they remind them of. There are no right or wrong answers.

1. Administration

Administration is divided into three parts:

a. The initial inquiry phase during which the subject responds to the cards.

b. The second inquiry phase when the examiner goes through the subject's responses to each card asking general questions to determine how the subject arrived at their response.

c. A third phase, or testing the limits, is undertaken only when the subject shows no reaction to some of the blots. The examiner might prompt the subject by offering: "some people have seen this as a butterfly, can you show me how that might be?"

2. Scoring (Hertz, 1987)

The subject's responses are classified with five characteristics:

a. Location	Where on the card the concept was seen.
b. Content	Content of the response.
c. Popular-Original	The frequency with which the response occurs in a normative sense.
d. Form Level	How accurately the concept is seen.
e. Determinant	Shape, color, shading, movement.

3. Interpretation

Since the interpretation includes the total responses to all cards, interpretation is quite complex. Refer to Beck for more detailed interpretive techniques (Beck, 1944).

B. Thematic Apperception Test (TAT)

The TAT is another commonly used projective test (Bellak, 1988). It was introduced by Morgan and Murray in 1935 and published in 1943 by Henry Murray. The test is made up of twenty-nine pictures and one blank card. There are four different combinations of nineteen pictures which are selected for age and sex, along with a blank card. The TAT is thought to be a good tool for measuring hostility and achievement.

1. Administration

The subject is shown each picture and is informed they have five minutes to tell a story of what they see taking place on the card. They are encouraged to disregard the commonplace settings and let their imagination run free in myth, fairy tale, or allegory. Some examiners offer only ten cards at a time on two separate days and some choose the pictures for particular themes.

During the administration, the examiner's task is to record the stories verbatim. Tape recorders are a tremendous help in recording the information accurately. If the stories become too detailed, or go on too long, the examiner may interrupt and ask how the story ends or simply stop and go to the next picture. Examiners may also ask for the feelings or thoughts of the story characters if this data is not presented.

2. Scoring and Interpretation

Murray proposes a scheme of content analysis which is based on his "need system" approach to personality (Murray, 1943). He recommends analyzing the stories in terms of the force or forces emanating from the hero and the same emanating from the environment. The first step is to analyze the hero's characteristics, motives, strengths, weaknesses, feelings, and needs or drives. The combining of the their needs, and the environmental forces, and the outcome of the story produces what Murray calls a "thema." The themas for all the stories provide the major basis for interpretation.

The CAT, Children's Apperception Test is used for young populations.

C. House Tree Person

This test is exactly like it sounds. In the House-Tree-Person projective drawing test, the person is asked to draw a picture of themselves, a house, and a tree. The test is evaluated by analyzing the structure of the pictures. The test is for individuals age five and up and can be used with couples and families. Scoring guidelines are provided with the test. This test is thought to be a good test to reveal information about home life, family relationships, anxiety and current or historical childhood influences.

D. Incomplete Sentences Blank

Individuals fill in the information that is left blank in a sentence. It is interpreted by the examiner based on their experience and knowledge of the individual. There are several lists, one is the Forer Structured Sentence Completion Test.

BEHAVIORAL ASSESSMENTS

1. Gathering data

A lot of information can be gathered by watching an individuals "stream of behavior." Observations are formalized by creating tracking systems that describe, in a narrative or coding system, information such as:

A. Type of behavior described in an objective measurable manner.

B. Schedule of behavior - time of day or smaller measures (how many times a minute).

C. Antecedents to the behavior.

D. Consequences of the behavior.

E. Secondary gains of the behavior.

2. Measurement techniques include

A. Interviews

B. Physiological measures

C. Self-reports

D. Direct observations

3. Creating a behavioral change program

Behavioral assessments are usually made as a precursor to creating a behavioral change plan using behavior modification treatment techniques. As information is gathered, three steps take place:

A. **The target behavior to be modified is identified.**

B. **The best behavioral intervention/s are formulated.**

C. **The original behavioral measures are used to assess the effectiveness of the behavioral treatment interventions.**

This information is then used to create a behavioral change plan. The behavior can be intervened at any place in the behavior stream.

Specific tests for children:

Burk's Behavioral Rating Scales
Auchenbach's Child Behavior Checklist

FAMILY ASSESSMENTS

The main point to remember in assessment of families is that, in contrast to traditional assessment, the focus is not on the individual, but rather on the interactional patterns of the family system. Bodin (1968) has listed three broad approaches to family assessment.

1. Types of approaches

A. **Individual Approach** - Each family member is assessed and scores are compared to produce an indirect picture of family interaction. Some commonly used instruments are Leary's Interpersonal Check List (ICL) and Schutz's FIRO-B.

B. **Conjoint Approach** - consisting of both objective and subjective methods for assessing families.

C. **Combined Approach** - that uses both individual and conjoint data, such as Strodtbeck's "revealed differences" technique. Structured family interviews are widely used by clinicians to assess family interaction style, and to identify family strengths and weaknesses. Two such forms of assessment follow.

2. Specific tests

A. **The Wiltwyck Family Task (Elbert et al., 1964)**

This test is made up of eight tasks the whole family must complete. The first six tasks are presented through a tape recorder as the examiner watches the family through a one-way mirror. This non-participant observer model is useful because it removes any impact the examiner might make on the task solving process.

The eight tasks prescribed in the audio tapes are:

1. Agreeing on a meal everyone would enjoy.
2. Discussing: "Who's the most bossy," "the biggest troublemaker," "the one who gets away with the most," and "the biggest cry baby in the family."
3. Discussing a remembered argument at home, including how it started, how it developed, and what the outcome was.
4. Agreeing on a way to spend a $10 gift that would satisfy everybody.
5. Asking each member to tell what things every other member does that pleases them the most and makes them feel good, and what things each one does that displeases them most and makes them feel unhappy or mad.
6. Reassembling an asymmetric construction, each member starting with an equal number of pieces.

The remaining tasks are presented by the observer, who leaves the room after offering gifts about which the family must make decisions:

7. The family is offered its choice of a single gift, given a limited value, i.e., $1, $5.
8. The family is offered refreshments but provided with one cupcake, one coke and one cup less than the number of members present. The family is left to decide how to dispense the food, and as in the previous task, they must live with the decisions that are made.

B. The Structured Family Interview

This interview was developed by "The Palo Alto Group" at the Mental Research Institute (MRI) in California. This test is designed to give observers clinical impressions in a very short time, one hour. The interview is conducted by an interviewer and observed by another therapist. After completion of the interview, the therapist is introduced to the family. The family has already been guided to look at themselves as an interacting unit. The procedure was created with two primary goals in mind, first to gather a significant amount of information about a complex system quickly, and also as a therapeutic intervention early in treatment.

1. The five tasks in the interview utilize individual, dyadic and whole-family observations. The interviewer observes the discussion through a one-way screen.
    a. First, each member is asked individually, away from the family group, "What do you think are the main problems in your family?" Then, the group is assembled, and told that several discrepancies arose in the individual responses (whether they did or not), and asked to discuss the question together.
    b. Second, the family is asked to plan something more complex, such as an outing.
    c. Third, with the children excused, the parents are asked to describe how they met each other.
    d. Fourth, the parents are asked to discuss the meaning of a proverb and then bring the children into the room and teach them the meaning of the proverb.

e. Fifth, the interviewer gives each person an index card and a pencil. Each member is asked to write down the main fault of the person on his left. The interviewer collects the cards and announces that he is adding two statements to the group responses. His statements are always "too good" and "too weak," but this fact is not revealed. After shuffling the cards, the interviewer reads each one to every member in turn, beginning with the father, and asks, "To whom do you think this applies?"

2. The major advantages of this type of approach are:

    a. It provides some common experience for researchers to use to make comparisons.

    b. The combination of common tasks or questions and open-ended (non restricted) responses have proved particularly popular.

C. Geneograms

Geneograms are family trees that include more detailed clinical and relational information. A wide range of information such as substance abuse, divorce, communication styles, and other information that helps identify the family and its dynamics are included.

VALUES ASSESSMENT

Values assessments range from the simple to the complex. They are based on the belief that individuals' behaviors are driven by their needs, which are then translated into personal values. Personal choices are made using the individual's personal values as the selection criteria.

APTITUDE TESTS

Aptitude tests are similar to intelligence tests but they are designed to measure a narrower range of capabilities. They are meant to measure the effects of general learning and to predict future performance. Some of the best known tests are:

1. Individual aptitude tests

A. General Clerical Tests

B. Musical Aptitude Profile

C. Purdue Pegboard

2. Multiaptitude test batteries

These are a number of tests or subtests that measure different aptitudes. These adapt themselves well to educational and vocational counseling in high school and college. They are also used by placement programs, state employment agencies, and the armed services.

A. Differential Aptitude Tests

1. Armed Services Vocational Aptitude Battery (ASVAB)
2. Career Ability Placement Survey (CAPS)
3. Flanagan Tests (FACT)
4. General Aptitude Test Battery (GATB)

B. Occupational Tests Of Special Aptitudes

These tests grew out of the work place trying to match employees to job descriptions. Tests include:

1. Clerical Aptitude Tests
2. Mechanical Aptitude Tests
3. Psychomotor Ability Tests

ACHIEVEMENT TESTS

Achievement testing is a measure of an individual's degree of mastery in a specific subject or task area. The tests can be designed by a teacher or standardized over an identified area. Different achievement tests are used for many purposes. They may test academic ability or professional ability, i.e., law exams, real estate licensing exams, etc.

Achievement tests may also be used diagnostically:

California Achievement Tests
Iowa Tests of Basic Skills
Stanford Achievement Test

1. Scholastic tests

Used in educational settings to predict future academic achievement.

Graduate Record Exam (GRE)
Miller Analogies Test
Scholastic Aptitude Test (SAT)

CAREER ASSESSMENT INSTRUMENTS

Interest and career measures compare the response of the tester with those of others at similar levels. One of the first career instruments was the Strong Vocational Interest Blank (SVIB). The revised edition, the Strong-Campbell Interest Inventory (SCII) is one of the most widely used and researched tests today.

1. Myers Briggs Type Indicator (MBTI)

The MBTI is a self-report instrument, meaning it measures your responses to the items. You, are the decision maker. The instrument is nonjudgmental. There is no right or wrong way to be, no correct or incorrect answers. When you take the MBTI, you choose some things and exclude others. The MBTI does not measure values or skills, but points out ways in which you can capitalize on your strengths.

People are different in fundamental ways yet there are similar drives that motivate us from within. The manner in which we pursue our needs and relate to others can be simplified, arranged into categories, and called preferences. By identifying what your preferences are, and those of people in your life, you can begin to appreciate differences rather than judge others as wrong or bad. The MBTI is elaborated on in a chapter in the test taking section.

2. Strong-Campbell

The Strong-Campbell is developed out of John Holland's theory of career development which notes six types of people and their environment:

Realistic	R
Investigative	I
Artistic	A
Social	S
Enterprising	E
Conventional	C

The test is a multiple choice test that is computer scored. Test results and many different types of narrative reports are available. The test compares individual interests with those of people successfully and happily employed in a large number of occupations.

3. Other tests commonly used in career counseling are:

Aptitude
Armed Services Vocational Aptitude Battery (ASVAB)
Career Ability Placement Tests (CAPS)
Differential Aptitude Tests (DAT)
General Aptitude Test Battery (GATB)

Interest
Career Assessment Inventory (CAI)
COPS Interest Inventory
Jackson Vocational Interest Survey
Kuder Vocational Preference Inventory
Ohio Vocational Preference Inventory
Self Directed Search (SDS)

Values
Career Orientation Placement and Evaluation Survey (COPES)
Minnesota Importance Questionnaire
Work Value Inventory

SELF-CONCEPTS, PERSONAL CONSTRUCTS AND SELF-REPORTS

Phenomenological psychology focuses on how individuals perceive events. Instruments can be used to assess how people view themselves and others. Self report inventories are often seen in popular magazines and are well received by clients. The clinician must be cautious in this arena since many tools have poor psychometric properties and no normative supporting information. On the other hand there are some instruments that have been used extensively and evaluated well. Some tests in this category include:

A. Personality Measures

- Millon Clinical Multiaxial Inventory (MCMI) - Adults 18 years plus with a minimum eighth-grade reading level. Assesses both Axis I and Axis II DSM disorders
- Edwards Personal Preference Schedule (EPPS)
- Personality Research Form (PRF)
- Washington University Sentence Completion Test - measures self conceptualization or ego development
- Self Esteem Measures
- Self-Esteem Scale (SES)
- Student Self-Concept Scale (SSCS)
- Personal and Academic Self-Concept Inventory (PASCI)
- Adjective Check List (ACL)
- Q-Sort
- Semantic Differential

B. Other Measures

- Role Construct Repertory Test - identifies client's constructs about others in their lives
- Perceived Environment and Social Climate
- Beck Depression Inventory (BDI)
- Fear Survey Schedule (FSS)
- Rathus Assertiveness Schedule (RAS)

COMMON TERMS

1. Standardized

A test can be called standardized for the "tester's" actions and language. The apparatus or equipment they use to test with have been fixed so that the test results collected are done at clearly identified times and in a particular manner. Any deviations from any of the above invalidates the test's outcome reports.

2. Performance measures

A well-defined task or situation is presented to the test taker and their performance is then measured. Maximum and minimum performance is assessed.

3. Self-report measures

Self-report is exactly as it sounds. The examinee reports to the clinician their beliefs, feelings, attitudes or any other information requested, to complete the assessment. Many personality tests are self-report.

4. Summative vs formative evaluation

Many achievement tests are used to evaluate instructional programs and/or materials. If an assessment, or assessment materials are provided during the learning process the outcomes can be used for formative evaluation. The goal being to optimize the materials or assessment process so the learner will learn more quickly or more in depth.

When a test is provided at the end of instruction, it is considered a summative evaluation of the effectiveness of the instruction in relationship to instructional goals.

Mental Status

CLIENT EVALUATION

1. The client evaluation consists of:

   A. **Conducting a clinical interview - gathering data from a careful history of the client's problems**

   B. **Conducting a mental status examination**

   C. **Developing a differential diagnosis**

   D. **Developing a treatment plan**

   E. **A physical examination may also be needed**

2. Most clients are not psychotic, however even confused and disorganized clients can be helped to give accurate details of their history.

3. It is important to retain confidentiality in all therapist-client interactions, but particularly when psychological issues are discussed. Therapists should not discuss their clients in public places.

4. The rule of confidentiality may be broken when the need for safety becomes paramount, such as in cases of child abuse, elder abuse or when threats are made to harm oneself or others. This information should be told to clients as early as possible.

PSYCHOLOGICAL INTERVIEW

1. The client must feel comfortable enough to give information.

2. Non-verbal communication is as important as verbal communication. Also note how the client presents the material (i.e., the tone of voice, the feelings expressed).

3. During the first few minutes of the interview, the therapist should allow the client to talk about his or her major problem as the client sees it.

52A

4. History of present illness. The interviewer should illicit information about:

- The onset or change over time of the symptoms.
- Stressful events, especially losses, including death, job loss, financial loss and any major changes in the client's life.
- The client's perception of any change in him or herself or report of any other individual's perception of change in the client.
- History of past psychiatric illness or treatment, including medications, hospitalizations, or other therapy.
- Any legal issues with regard to the present illness or, in the case of children, any problems in school.
- Any possible secondary gain - anything the client may see as being gained from the current problem, such as monetary compensation or relief from responsibilities at home, school, or work.

5. Personal history

A. Developmental Milestones

1. Early childhood development, including details about prenatal care, pregnancy and delivery.
2. Information regarding the client's temperament as a child as well as any important family events, such as death, separation, or divorce, that may have influenced the development of the temperament.
3. School (i.e., grades or delinquency), friends, family stability, early sexual experiences, neglect or abuse, the client's relationships as a child with his or her parents, siblings, and friends.

B. Social History

1. Gather information regarding the client's social life, such as is he or she a loner, how hard or easy is it for the client to make or keep friends.
2. Have any changes in personality been noted by the client or by his or her family or friends.
3. What is the marriage/partnership status and the current level of sexual functioning.
4. Determine the employment history, including the number of jobs the client has had, the reasons the jobs were terminated - note any problems with alcoholism or antisocial behavior.
5. Obtain a military service history including the highest rank attained and a history of any disciplinary problems or combat experience.

C. Family History

1. Information should be obtained about psychiatric illness, hospitalizations or any other kind of mental health treatment of a family member, including suicide attempts, problems with alcohol, or other psychiatric problems.

2. If possible, gather information regarding genetic risk factors as well as family attitudes toward mental illness and treatment.

3. Determine if any psychotropic medication is being used successfully by a family member for the same illness. There is a good chance that this medication will also be helpful to the present client.

D. Psychiatric History

Obtain information about any previous problem, including previous treatment, the name and address of the therapist, medications, and the outcome of treatment.

E. Use and Abuse of Substances

Always ask screening questions about alcohol and drug use, including whether or not family or friends ever objected to the client's drinking or drug problem or whether the client ever felt that he or she had a problem with alcohol or drugs (legal or illegal), including caffeine and tobacco. Obtain information about alcohol and drug use of other family members, presently and historically.

MENTAL STATUS EXAMINATION

The psychological history is a record of the client over the course of his or her entire life, whereas the mental status examination is an evaluation of the client at one point in time. During the interview, the clinician should make note of the following:

1. Appearance

A general description of overall appearance, dress, grooming, and any unusual features or gestures, particularly those that make the client unique or different should be noted.

2. Behavior and psychomotor activity

The clinician should note gait, position, and overall level of activity, noting any twitches, mannerisms, tics, agitation, or psychomotor retardation, clumsiness, rigidity, combatitiveness. Manic clients may be unable to sit still, whereas schizophrenic clients may exhibit bizarre postures or be abnormally stiff and awkward.

3. Attitude

It is important to note how the client relates to the clinician and to being interviewed, including whether the client is, e.g., cooperative, uncooperative, bored, seductive, hostile, frank, defensive, playful, evasive, guarded.

4. Speech

The clinician should describe how the client speaks: rapid, slow, pitch, pressured, hesitant, emotional, monotonous, loud, whispered, slurred, ease, mumbled, relevance, manner, speech impairments (distinguish Aphasia which is due to neurological, not psychological illness).

5. State of consciousness

The client's alertness, responsiveness to environment, orientation, ability to carry out tasks (e.g. simple, then complex, ex: touching nose with finger, then touching another body part simultaneously) should be noted.

6. Mood and affect

"Mood" is the client's internal emotional state, while "affect" is the outward expression of the internal state. Determine if the mood and affect are congruent.

A. **How does client say he/she feels;** depth, intensity, duration and fluctuation of mood - depressing, despairing, irritable, panicky, terrified, angry, enraged.

B. **How does the interviewer evaluate the client's mood and affect:** manic, hypomanic, grandiose, agitated, flat, labile.

C. **Is the emotional expression appropriate** to the content, to the culture, to what the client is saying.

7. Anxiety level

A. **Client's Description:** are anxieties generalized and nonspecific or specifically related to particular situations, activities, or objects.

B. **How Are Anxieties Handled:** avoidance, repetition of feared situation, drugs or alcohol, other activities for distraction.

C. **Observations:** signs of anxiety - moist hands, perspiring forehead, restlessness, tense posture, strained voice, wide eyes, shifts in level of anxiety during interview, abrupt changes of topic.

8. Perception

Perceptual abnormalities involve the sensory nervous system and include:

A. Hallucinations

Hallucinations are false perceptions of a sensory stimulus in the absence of a sensory stimulus. Any sensory modality can be involved: auditory, visual, gustatory (taste) and olfactory (smell) tactile, and kinesthetic hallucinations. Hallucinations of any sort that occur while falling asleep (hypnagogic) or awakening (hypnopomic) are not necessarily considered serious or pathologic and are seen in normal individuals.

B. Illusions

An illusion is the misinterpretation of a true sensory stimulus. Illusions can be present in schizophrenia but are most common in delirium.

C. **Depersonalization and Derealization** are alterations in the perception of one's reality. With depersonalization, the client feels detached and views him or herself as strange and unreal. Derealization involves a similar alteration in the sense of reality of the outside world. Objects in the outside world may seem altered in size and shape, and people appear dead or mechanical.

9. Thinking process

The pattern of a client's speech allows the examiner to note the quality of the thought process, including its flow, logic, and associations. Abnormalities of the thinking process include:

A. **Abstract Reasoning** reflects the ability to understand concepts of similarities and differences, categories and classifications of items, behavior, etc., and perspective in relation to events.

B. **Loose Association** is the shifting of ideas from one to another with no logical connection. There is a lack of awareness on the part of the client that these ideas are not connected. The client's thoughts are difficult for the examiner to follow.

C. **Tangential Thinking** occurs when the client wanders off the subject as new but related words are spoken. The associations are not totally loose but the client often loses track of the question or point.

D. **Circumstantiality** occurs when the client loses the point of what he or she is trying to say but stays in the general topic area. Irrelevant details can be included if the client is merely anxious but can be severe if the client is delirious and distractible.

E. **Blocking** occurs when the thinking process stops altogether. The mind goes blank. Blocking can occur in states of acute anxiety as well as in schizophrenia.

F. **Perseveration** is the repetition of the same words or phrases over and over again.

G. **Echolalia** is the direct repetition of the interviewer's words, like a parrot.

H. **Flight of Ideas,** as seen in mania, involves rapid speech with quick changes of ideas that may be associated or may also involve loose associations.

10. Content of thought

Disturbances in the thought content include:

A. **Delusions,** which are fixed, false beliefs that are outside the client's culture. Delusions can be paranoid (or persecutory), grandiose, nihilistic, somatic, or bizarre. Delusions of reference involve the belief by the client that some person or object has special significance or power.

B. **Obsessions** are intrusive thoughts, ideas, or impulses that are persistent. The client recognizes that the ideas do not make sense and are not being imposed from outside (a delusion). Some commonly found obsessions are fears of contamination or obsessive unrealistic fears about physical health as seen in hypochondriasis.

11. Judgment

The social judgment of the client, i.e., whether the client understands the consequences of his or her actions should be assessed by the clinician. The clinician must, however, recognize differences in cultural values when assessing judgment.

12. Memory

The ability to recall and/or recognize the remote and recent past.

13. Intelligence

Assessment should be made of the general level of intellectual function of the client.

14. Concentration and attention span

The ability of the client to attend to and focus on tasks should be assessed.

15. Orientation

A formal mental status examination includes an assessment of a client's orientation to time (time, date, year), place (where client is) and person (who client is, and who clinician is).

THE CLINICAL REPORT

The clinical report includes:

1. **Preliminary identification:** name, age, marital status, sex, occupation, language if other than English; race, nationality, and religion (if pertinent), earlier episode of the same or a different condition.
2. **Chief complaint:** why did the person come to the office, preferably noted in the person's own words. If this information is given by someone else, state who supplied it.
3. **Personal identification -** brief description of appearance and behavior.
4. **History of present illness -** background and development of symptoms or behavioral changes that led person to seek assistance.
5. **Previous illnesses -** emotional or mental disturbances.
6. **Psychophysiological disorders -** ex: hay fever, rheumatoid arthritis, asthma, skin conditions.
7. **Past personal history**
    - Early childhood
    - Later childhood
    - Adulthood
8. **Family history**
9. **Marital history**
10. **Current social situation**

MENTAL STATUS ASSESSMENT WORKSHEET

Appearance

Aloof
Anxious
Dejected
Depressed
Distractible
Elated
Hyperactive
Hyper Alert
Lethargic
Neat
Peculiar Dress
Postural Problems
Psychomotor Retardation
Restless
Slovenly
Tense
Vigilant
Other

Attitude

Cold
Condescending
Cooperative
Demanding
Deprecatory Of Self
Disdainful
Disinterested
Egocentric
Evasive
Frank
Hostile
Over Idealizing Others
Self-Deprecatory
Sensitive
Superior
Suspicious
Vain
Other

Behavior

Aggressive
Angry
Argumentative
Arrogant
Assertive
Assaultive
Belligerent
Bizarre
Cheerful
Critical
Dependent
Dramatic
Exploitative
Exhibitionist
Friendly
Grossly Disorganized
Guarded
Helpless
Hostile
Indecisive
Ingratiating
Irritable
Irascible
Limited Empathy
Manipulative
Negativistic
Passive
Seeking Reassurance
Subdued
Obsequious
Secretive
Verbally Abusive
Other

Behavioral Difficulties

Arrests
Breaking Rules
Delinquency
Impulse Control
  Adequate
  Impaired
Initiation Of Fights
Persistent Lying
Repeated Drunkenness Or
Substance Abuse
Running Away From Home
Sexual Promiscuity
Thefts
Vandalism
Other
None Of The Above

Disturbances Of Motor Impairment

Apraxia
Aphoria
Catatonia
Echopraxia
Fainting
Fatigability
Hyperactivity
Jitteriness
Loss Of Control Of:
  Sphincters
  Voluntary Muscles
Muscle Aches
Negativism
Paralysis
Posturing
Retardation
Shakiness
Stupor
Trembling
Tremors
Other
None Of The Above

Somatic Changes Or Physical Complaints

- Changes In Eating Patterns
- Chest Pain Or Discomfort
- Choking Or Smothering Sensations
- Dyspnea
- Dizziness, Fatigue
- Faintness
- Factitious Complaints
- Hot And Cold Flashes
- Hypersomnia
- Insomnia
- Menstrual Difficulties
- Pain
- Palpitations
- Paresthesias
- Sexual Drive Decreased
- Sweating
- Trembling Or Shaking
- Vertigo Or Unsteady Feelings
- Vomiting
- Weight Gain
- Weight Loss

Autonomic Hyperactivity

- Circulatory System:
  - Flushing
  - Palpitations
  - Pallor
  - Pulse Rate Increase
- Gastrointestinal System:
  - Diarrhea
  - Discomfort
  - Dry Mouth
  - Nausea
  - Vomiting
- Respiratory System:
  - Hyperventilation
  - Increased Rate
- Miscellaneous:
  - Cold Clammy Hands
  - Dizziness
  - Paresthesias
  - Sweating
- Other
- None cf the Above

Speech And Thought Progression

- Range:
  - Average
  - Decreased
  - Increased
  - Mute
  - Pressured
  - Other
- Progression:
  - Blocking
  - Circumstantial
  - Changeable
  - Concrete
  - Condensed
  - Concentration Loss
  - Digressive
  - Echolalic
  - Flight Of Ideas
  - Incoherent
  - Indecisive
  - Irrelevant
  - Loosening Of Associations
  - Neologistic
  - Over Elaborate
  - Perseverative
  - Poverty Of Content
  - Stereotypy
  - Tangential
  - Vague
  - Verbigeration
  - Word Salad
  - Other
- None of the Above

Affect

- Aloof
- Apathetic
- Appropriate
- Blunted
- Cold
- Flat
- Inappropriate
- Irritable
- Labile
- Temper
- Outbursts
- Other

Mood

- Anxious
- Elevated
- Depressed
- Within Normal Limits
- Other
- Supplemental Information Regarding Mood
- Is Anxious Mood Associated With:
  - Compulsions
  - Obsessions
  - Panic Attacks
  - Phobias
- Is Depressed Mood Associated With:
  - Agitation
  - Early-Morning Awakening
- Decreased Effectiveness At:
  - School
  - Home
  - Work
- Decreased Enjoyment
- Feeling Worse In The Morning
- Feeling Inadequate
- Feeling Slowed Down
- Guilt
- Loss Of Interest Or Enjoyment In Sex
- Pessimism
- Tearfulness
- Is Elevated Mood Associated With:
  - Decreased Need For Sleep
  - Hyper Sexuality
  - Distractibility
  - Poor Judgment
- Excessive Involvement With Pleasure
- Increased:
  - Creativity
  - Energy
  - Feelings Of Omnipotence
  - Optimism
  - Physical Activity
  - Talkativeness
  - Inappropriate Joking
  - Laughing or Punning

Perceptions

- Delusions Or Feelings Of:
  - Being Controlled
  - Blamelessness
  - Body Image Disorder
  - Disorganization
  - Dying
  - Entitlement
  - Forgetfulness
  - Going Crazy
  - Grandiosity
  - Guilt
  - Helplessness
  - Hypersensitivity
  - Inability To Express Warmth
  - Ideas Of Reference
  - Inadequacy
  - Indifference
  - Indecisiveness
  - Ineffectiveness
  - Inflated Worth
  - Insistence Upon Having Ones Own Way
  - Jealousy
  - Knowledge
  - Limited Pleasure In Life
  - Losing Control
  - Magical Thinking
  - Nihilism
  - Objectivity
  - Paranoia
  - Persecution
  - Poverty
  - Power
  - Religious Nature
  - Self Reproach
  - Special Identity
  - Somatic
  - Stubbornness
  - Suspiciousness
- Thought:
  - Broadcasting
  - Insertion
  - Withdrawal
  - Unreality
  - Worthlessness
- Other
- None of the Above

Hallucinations

- Auditory
- Olfactory
- Gustatory
- Taste
- Visual
- Depersonalization:
  - Yes No
- Fears Or Phobias:
  - Yes No
- If Yes, Are They:
  - Social
  - Spatial
  - Animal
  - Other
- Illusions: Yes No
- Intellectualization:
  - Yes No
- Obsessions, Compulsions, And Recurrent Thoughts
  - Yes No
- Ego Dystonic
- Ego Syntonic
- Both
- Over Determined Ideas, Preoccupation, And Trends:
  - Yes No
- Level Of Consciousness:
  - Clear
  - Clouded
  - Comatose
- Memory Impairment:
  - Yes No
- If Yes, Is There Impairment Of:
  - Immediate Recall
  - Recent Recall
  - Past Recall
  - Confabulation

Orientation

- Person
- Place
- Time
- Calculations:
  - Normal
  - Impaired
- Aphasia
- Agnosia
- Difficulty In Naming Parts Of The Body
- Level Of Information:
  - Low
  - Average
  - High

Intelligence

- Superior
- Bright
- Average
- Dull Normal
- Borderline
- Retarded

Judgment And Insight

- Judgment
  - Adequate
  - Impaired
- Insight
  - Adequate
  - Impaired
- Amnesiac Disturbances:
  - Yes No

Disturbance of Organs of Special Sense

- Auditory
  - Deafness
  - Hearing Loss
- Touch
  - Anesthesia
  - Numbness
- Visual
  - Blindness
  - Blurred Vision
  - Double Vision
- Other
- None of the Above

Assessment

Reliability of Information
Low/1 2 3 4 5/High
Immediate Treatment Interventions
Immediate Treatment Goals
Initial Prognosis
Referrals/Consultations
Working Diagnosis DSM-IV
Axis I
Axis II
Axis III
Axis IV
Axis V

CHAPTER 4

Diagnosis

DSM IV

1. History

The first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) was developed by the American Psychiatric Association in 1952. It used a psycho-biological approach and biological processes were believed to have caused most psychological problems. DSM-II was developed in 1968 and used until 1980. It established characteristics for psychosis and neurosis. DSM-III was used from 1980 until 1987. In this version the language was easier to understand and an attempt was made to be non-pejorative. This is the first version where both medical and non-medical persons worked together in the writing, giving credence to the idea that non-medical persons would also use the manual. This version of the DSM was more contemporary as the writers were more aware of societal changes. DSM-III-R (1987) was a further refining of DSM-III. The code numbers were tied into the ICD-9-CM, the International Classification of Diseases - Clinical Modification, ninth edition. The ICD is the manual used by the World Health Organization and was developed in Paris in 1900. It is revised approximately every 10 years. In 1994, the DSM-IV was released. This version emphasized the reciprocal relationship between biological problems and psychological disorders to a greater degree than any rendition since DSM-I. In a few places, the same code is used for more than one diagnosis. This happened because these diagnoses were together in the ICD and when separated for the DSM, the code remained the same in order to tie into the ICD. The DSM-IV will correlate with ICD-10 diagnostic codes when they are published. The DSM-IV is atheoretical, meaning that no one theory of diagnosing mental disorders is represented, thus all theories of intervention can be used in treatment.

The information in this chapter was developed with the help of the Introduction to DSM-IV, Linda Seligman, Ph.D., LPC, CCMHC, Workshop, Boston, MA, Oct., 1994.

2. Definition of a Mental Disorder

"In the DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above" (p. xxi - xxii, DSM-IV).

A. The Multiaxial System:

1.	Axis I	Clinical Syndromes and Other Conditions That May Be a Focus of Clinical Attention
2.	Axis II	Personality Disorders Mental Retardation
3.	Axis III	General Medical Conditions
4.	Axis IV	Psychosocial and Environmental Problems
5.	Axis V	Global Assessment of Functioning

B. The multiaxial classification system looks at the client through five lenses, seeing the whole person, and taking a holistic view. It is the basis for treatment planning. Axes I and II look at client symptoms and are the heart of the diagnosis.

1. Axis I — Disorders are generally transient and are typically preceded by a period of emotional health. In most cases, the therapist hopes that the client will be totally free of the disorder at some later point.

2. Axis II — Disorders are long-standing, deeply ingrained, potentially life-long and are ego-syntonic (a fundamental part of the person).

3. Axis I—Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention

If there is more than one diagnosis on Axis I, list them in order of treatment priority. The first diagnosis is the primary diagnosis and the focus of treatment.

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (excluding Mental Retardation, which is diagnosed on Axis II)
Delirium, Dementia, and Amnestic and Other Cognitive Disorders
Mental Disorders Due to a General Medical Condition
Substance-Related Disorders
Schizophrenia and Other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Factitious Disorders

Dissociative Disorders
Sexual and Gender Identity Disorders
Eating Disorders
Sleep Disorders
Impulse-Control Disorders Not Elsewhere Classified
Adjustment Disorders
Other Conditions That May Be a Focus of Clinical Attention (except borderline intellectual functioning)

4. Axis II—Personality Disorders and Mental Retardation

There can be more than one diagnosis on Axis II (may also include personality traits and defense mechanisms).

Paranoid Personality Disorder
Schizoid Personality Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Personality Disorder Not Otherwise Specified
Mental Retardation

5. Axis III—General Medical Conditions

A condition listed on Axis III must be diagnosed by a physician and have an ICD-9-CM (or ICD-10-CM) code number. Current general medical conditions that are potentially relevant to the understanding or management of the person's mental disorder are reported. The medical condition is obtained by sending a signed Release of Information form to the physician requesting the results of the client's most recent physical examination. Some ICD-9-CM and ICD-10-CM numbers are listed in Appendix G of the DSM-IV. If the physician's specific diagnosis is not listed in Appendix G, contact the physician for the correct number. Medical conditions listed on Axis III are provisional until confirmation is received from a medical doctor, for example: "ulcers (provisional)". As soon as the information is obtained, Axis III should be changed to reflect the new information and "(provisional)" is deleted.

6. Axis IV—Psychosocial and Environmental Problems

Axis IV is a view of the client's world: what stressors are experienced in the client's outside world (not internal processes). Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II). These may include life events, familial or other interpersonal stress, inadequacy of social support or personal resources. Axis IV may also include so-called "positive stressors" such as job promotion or the birth of a child, if they constitute or lead to a problem. Since there is no rating scale for Axis IV, merely list the stressors that the client has experienced in the previous year.

7. Axis V—Global Assessment of Functioning (GAF) Scale (1-100)

Axis V is for reporting the clinician's judgment of the client's overall level of functioning. This information is useful in treatment planning and measuring it's impact, as well as in predicting outcome. The GAF scale looks at the client's resources or coping. The rating is given on the client's current level of functioning, only.

90 - 100	Superior level of functioning - probably won't see these people in counseling.
80 - 90	Well-functioning people - they may have minor snags in their life, but usually won't have a mental disorder.
70 - 80	May have an Adjustment Disorder - they may be reactive people.
50 - 70	May see these people in outpatient settings - they may have anxiety and mood disorders - they are in touch with reality and are functioning, but can have severe problems.
50 and Below	These people have serious symptoms - they are in danger (therapist may think about inpatient recommendations) the lower the number, the more serious - they may have been in inpatient treatment sometime in their history - they may have to be maintained on medication.

8. Other Concepts Used in Diagnosis:

A. Code Numbers

DSM-IV gives three to five code numbers for each diagnosis. If there is an X in the 4th or 5th digit, replace the X with a number. It gives information regarding severity and other information.

B. Prior History

The client may have recovered from the disorder, but it is clinically important to note the history.

C. Degree of Severity

For each disorder, the seriousness of the client's symptoms should be indicated, particularly on Axis I. DSM-IV gives a set of criteria for each disorder. Designation of "Mild" meets the minimum number required, "Severe" meets all or almost all of the criteria and is significant impairment, "Moderate" is somewhere in between.

D. In Partial Remission

"In Partial Remission" is used when the full disorder had been met previously, but presently only some of the symptoms are in evidence or some of the symptoms have reappeared following a period of full remission.

E. In Full Remission

"In Full Remission" is used when the symptoms are no longer in evidence but it is still clinically relevant to note a history of the disorder or if the client has been on medication and is now off the medication and has been symptom-free for a long time.

F. "Rule Out" or "R/O"

"Rule out" or "R/O" is used when symptoms are similar for more than one disorder and more information is needed to determine the correct diagnosis.

G. "Provisional Diagnosis"

"Provisional Diagnosis" is used when there is a strong presumption that the full criteria will be met for a disorder, but more information is needed to make a firm diagnosis.

H. "Not Otherwise Specified" or "NOS":

"Not Otherwise Specified" or "NOS" is noted at the end of most categories and is used when the symptoms do not meet the specific criteria of any disorder, but some symptoms fit into the category. It is not to be used as a "catch-all".

I. Some of the code numbers are the same for more than one diagnostic category (because of the connection with ICD-9 or 10-CM), therefore it is important that the name of the diagnostic category be given as well as the number.

J. Example of how to record results of a DSM-IV evaluation:

Axis I	303.90	Alcohol Dependence
	296.33	Major Depressive Disorder, Recurrent, Severe without Psychotic Features
Axis II	301.6	Dependent Personality Disorder
		Frequent use of denial
Axis III	531.30	Ulcer, gastric, acute (code from ICD-9-CM)
Axis IV	531.70	Threat of job loss
Axis V	GAF	35 (current)

9. Cultural Formulation

A narrative paragraph may be added to address the relationship of socio-cultural factors to the diagnosis. The cultural formulation provides a systematic review of the individual's cultural background and the role of the cultural context in the expression and evaluation of the person's symptoms and dysfunctions. Also included are the effects that cultural differences may have on the relationship between the client and the clinician. The Cultural Formulation should be used if the clinician is working with a client from a different culture than her/his own. A narrative summary for each of the following categories may be included:

- Cultural identity of the individual
- Cultural explanations of the individual's illness
- Cultural factors related to the psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and the clinician
- Overall cultural assessment for diagnosis and care

THE DIAGNOSTIC CATEGORIES

Axis I - Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention. Explanations of the major categories are included here. It is recommended that each counselor have her/his own copy of the complete DSM-IV. For more detailed explanations refer to your

Note: Asterisks (*) denote changes from DSM-III-R.

Note: Numbers incorporate the 1996 updates from the American Psychiatric Press.

1. Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

(excluding Mental Retardation which is coded on Axis II).

A. Mental Retardation (code on Axis II)

Mental Retardation is defined as below average intellectual functioning, with onset before age 18, and concurrent deficits or impairments in adaptive functioning.

317	Mild Mental Retardation (IQ 50-55 to 70)
318.0	Moderate Mental Retardation (35-40 to 50-55)
* 318.1	Severe Mental Retardation (20-25 to 35-40)
318.2	Profound Mental Retardation (below 20-25)
319	Mental Retardation, Severity Unspecified

B. Learning Disorders (formerly Academic Skills Disorders)

Learning Disorders is defined as achievement on individually administered, standardized tests in reading, math, and written expression which is substantially below what would be expected for the age, schooling, and level of intelligence.

* 315.00	Reading Disorder
315.1	Mathematics Disorder
315.2	Disorder of Written Expression
315.9	Learning Disorder Not Otherwise Specified

C. Motor Skills Disorder

Motor Skills Disorders are marked impairments in the development of motor coordination.

* 315.4	Developmental Coordination Disorder

D. Communication Disorders

Communication Disorders are impairments in the areas listed below as demonstrated by scores on standardized, individually administered measures.

315.32	Mixed Receptive-Expressive Language Disorder
315.31	Expressive Language Disorder
315.39	Phonological Disorder (formerly Developmental Articulation Disorder)
307.0	Stuttering
307.9	Communication Disorder NOS

E. Pervasive Developmental Disorders

These disorders are defined as broad-based, severe and pervasive impairment or loss of functioning that would not be generally expected for the child's chronological age: social interaction skills, communication skills, or the presence of stereotyped behavior, interests or activities. These disorders are usually evident in the first 5 years of life and often associated with some degree of mental retardation (which, if present, is coded on Axis II).

299.00	Autistic Disorder
299.80	Rett's Disorder
299.10	Childhood Disintegrative Disorder
* 299.80	Asperger's Disorder
299.80	Pervasive Developmental Disorder NOS

F. Attention-Deficit and Disruptive Behavior Disorders

These disorders consist of a persistent pattern of disruptive, self-injurious, socially unacceptable, and/or environmentally destructive behaviors. Some symptoms must have been present before age 7. Diagnosis may be made into adulthood.

314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
314.00	Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Type
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
314.9	Attention-Deficit/Hyperactivity Disorder NOS
312.xx	Conduct Disorder (specify whether Childhood-Onset Type, Adolescent-Onset type, Unspecified Onset)
313.81	Oppositional Defiant Disorder
* 312.9	Disruptive Behavior Disorder NOS

G. Feeding and Eating Disorders of Infancy or Early Childhood

Feeding and Eating Disorders consist of persistent disturbances of ingesting inappropriate substances, frequent regurgitating and rechewing food, or failure to gain or lose a significant amount of weight because of not eating adequately.

307.52	Pica
307.53	Rumination Disorder
307.59	Feeding Disorder of Infancy or Early Childhood

H. Tic Disorders

An irresistible, sudden, rapid, recurrent, stereotyped motor movement or vocalization.

307.23	Tourette's Disorder
307.22	Chronic Motor or Vocal Tic Disorder (more than 1 yr.)
307.21	Transient Tic Disorder (specify if single episode or recurrent)
307.20	Tic Disorder NOS

I. Elimination Disorders

Elimination of feces (Encopresis) or urine (Enuresis) at inappropriate times or places.

* 787.6	Encopresis With Constipation and Overflow Incontinence
* 307.7	Encopresis Without Constipation and Overflow Incontinence
307.6	Enuresis (Not Due to a General Medical Condition)

J. Other Disorders of Infancy, Childhood, or Adolescence

A diverse group of persistent disorders beginning in infancy, childhood, or adolescence including specific anxiety (separation), selective verbal expression (mutism), attachment (to care givers) and movement problems.

309.21	Separation Anxiety Disorder (specify if early onset or before age 6)
313.23	Selective Mutism (formerly Elective Mutism)
313.89	Reactive Attachment Disorder of Infancy or Early Childhood
307.3	Stereotypic Movement Disorder (formerly Stereotypy/Habit Disorder) (specify if with self-injurious behavior)
313.9	Disorder of Infancy, Childhood, or Adolescence NOS

2. *Delirium, Dementia, and Amnestic and other Cognitive Disorders

Multiple deficits in cognition or memory that represent a significant change from a previous level of functioning. The etiology is either the direct physiological effects of a general medical condition or the result of substance use or a combination of both.

A. Delirium

Delirium is a cognitive disorder characterized by impairment in consciousness, attention, and cognition such as: memory deficit, disorientation, language or perceptual disturbance.

293.0	Delirium Due to . . . (Indicate the General Medical Condition)
-.-	Substance Intoxication Delirium (code by substance)
-.-	Substance Withdrawal Delirium (code by substance)
-.-	Delirium Due to Multiple Etiologies (use multiple codes)
780.09	Delirium NOS

B. Dementia

Dementia is a cognitive disorder characterized by defects in memory, loss of ability to use or understand words (aphasia), inability to carry out motor activities despite intact comprehension and motor function (apraxia), failure to recognize or identify objects despite intact sensory function (agnosia), and executive functioning (cognitive abilities such as planning, organizing, sequencing, and abstracting).

290.xx.	Dementia of the Alzheimer's Type (specify if with or without behavioral disturbance) (also code 331.0 Alzheimer's Disease on Axis III)
With Early Onset: if onset at age 65 or before	
290.10	Uncomplicated
290.11	With Delirium
290.12	With Delusions
290.13	With Depressed Mood
With Late Onset: if onset after age 65	
290.0	Uncomplicated
290.3	With Delirium
290.20	With Delusions
290.21	With Depressed Mood
290.4x	Vascular Dementia (Multi-Infarct Dementia)
290.40	Uncomplicated

290.41	With Delirium
290.42	With Delusions
290.43	With Depressed Mood

Dementia Due to Other General Medical Conditions:

294.1	Dementia Due to HIV Disease
294.1	Dementia Due to Head Trauma
294.1	Dementia Due to Parkinson's Disease
294.1	Dementia Due to Huntington's Disease
290.10	Dementia Due to Pick's Disease
290.10	Dementia Due to Creutzfeldt-Jacob Disease
294.1	Dementia Due to . . . (Indicate the General Medical Condition not listed above)
-.-	Substance-Induced Persisting Dementia (code based on specific substance)
-.-	Dementia Due to Multiple Etiologies (use codes for specific etiologies)
294.8	Dementia NOS

C. Amnestic Disorders

Amnestic Disorders are cognitive disorders characterized by impairment of memory which is manifested in an inability to learn new information and to recall previously learned information.

294.0	Amnestic Disorder Due to . . . (Indicate the General Medical Condition) (specify if transient [lasts for 1 month or less] or chronic [lasts for more than 1 month])
-.-	Substance-Induced Persisting Amnestic Disorder (code based on specific substance)
294.8	Amnestic Disorder NOS

D. Other Cognitive Disorders

294.9	Cognitive Disorder NOS

3. *Mental Disorders due to a General Medical Condition not Elsewhere Classified (code medical condition on Axis III)

The presence of mental symptoms that are judged to be the direct physiological consequence of a general medical condition coded on Axis III.

293.89	Catatonic Disorder Due to . . . (Indicate the General Medical Condition)
310.1	Personality Change Due to . . . (Indicate the General Medical Condition) (specify type: labile, disinhibited, aggressive, apathetic, paranoid, other, combined, unspecified)
293.9	Mental Disorder NOS Due to . . . (Indicate the General Medical Condition)

4. *Substance-Related Disorders

Substance-Related Disorders are disorders related to the excessive or inappropriate taking of a drug, due to the side effects of a medication or to toxin exposure.

Relevant Terminology:

Dependence is a group of cognitive, behavioral and physiological symptoms that indicate the person is continuing to use the substance despite significant substance-related problems (minimum of 3 of 7 criteria within 1 year)

Abuse is a maladaptive pattern of substance use which is recurrent and has significant adverse consequences related to the repeated use of substances (min. of 1 of 4 criteria within 1 year).

Course Specifiers:

- With or without physiological dependence
- Remission (specify if early full, early partial, sustained full, sustained partial)
- On agonist therapy (Methodone, Antibuse - for alcohol)
- In a controlled environment (incarcerated, hospitalized, etc.)

A. Alcohol Related Disorders

1. Alcohol Use Disorders

303.90	Alcohol Dependence
305.00	Alcohol Abuse

2. *Alcohol-Induced Disorders (moved from Organic Mental Disorders)

303.00	Alcohol Intoxication
291.81	Alcohol Withdrawal
291.0	Alcohol Intoxication Delirium
291.0	Alcohol Withdrawal Delirium
291.2	Alcohol-Induced Persisting Dementia
291.1	Alcohol-Induced Persisting Amnestic Disorder

3. Alcohol-Induced Psychotic Disorder:

291.5	With Delusions
291.3	With Hallucinations
291.89	Alcohol-Induced Mood Disorder
291.89	Alcohol-Induced Anxiety Disorder
291.89	Alcohol-Induced Sexual Dysfunction
291.89	Alcohol-Induced Sleep Disorder
291.9	Alcohol-Related Disorder NOS

B. Amphetamine (or Amphetamine-Like)-Related Disorders

1. Amphetamine Use Disorders

304.40	Amphetamine Dependence
305.70	Amphetamine Abuse

2. *Amphetamine-Induced Disorders

292.89	Amphetamine Intoxication
292.0	Amphetamine Withdrawal
292.81	Amphetamine Intoxication Delirium

3. Amphetamine-Induced Psychotic Disorder:

292.11	With Delusions
292.12	With Hallucinations
292.84	Amphetamine-Induced Mood Disorder
292.89	Amphetamine-Induced Anxiety Disorder
292.89	Amphetamine-Induced Sexual Dysfunction
292.89	Amphetamine-Induced Sleep Disorder
292.9	Amphetamine-Related Disorder NOS

C. Caffeine Related Disorders

1. *Caffeine-Induced Disorders

305.90	Caffeine Intoxication
292.89	Caffeine-Induced Anxiety Disorder
292.89	Caffeine-Induced Sleep Disorder
292.9	Caffeine-Related Disorder NOS

D. Cannabis-Related Disorders

1. Cannabis Use Disorders

304.30	Cannabis Dependence
305.20	Cannabis Abuse

2. *Cannabis-Induced Disorders

292.89	Cannabis Intoxication
292.81	Cannabis Intoxication Delirium

3. Cannabis-Induced Psychotic Disorder:

291.11	With Delusions
292.12	With Hallucinations
292.89	Cannabis-Induced Anxiety Disorder
292.9	Cannabis-Related Disorder NOS

E. Cocaine-Related Disorders

1. Cocaine Use Disorders

304.20	Cocaine Dependence
305.60	Cocaine Abuse

2. *Cocaine-Induced Disorders

292.89	Cocaine Intoxication
292.0	Cocaine Withdrawal
292.81	Cocaine Intoxication Delirium

3. Cocaine-Induced Psychotic Disorder:

291.11	With Delusions
292.12	With Hallucinations
292.84	Cocaine-Induced Mood Disorder
292.89	Cocaine-Induced Anxiety Disorder
292.89	Cocaine-Induced Sexual Dysfunction
292.89	Cocaine-Induced Sleep Disorder
292.9	Cocaine-Related Disorder NOS

F. Hallucinogen-Related Disorders

1. Hallucination Use Disorders

304.50	Hallucinogen Dependence
305.30	Hallucinogen Abuse

2. *Hallucinogen-Induced Disorders

292.89	Hallucinogen Intoxication
292.89	Hallucinogen Persisting Perception Disorder (Flashbacks)
292.81	Hallucinogen Intoxication Delirium

3. Hallucinogen-Induced Psychotic Disorder:

291.11	With Delusions
292.12	With Hallucinations
292.84	Hallucinogen-Induced Mood Disorder
292.89	Hallucinogen-Induced Anxiety Disorder
292.9	Hallucinogen-Related Disorder NOS

G. Inhalant-Related Disorders

1. Inhalant Use Disorders

304.60	Inhalant Dependence
305.90	Inhalant Abuse

2. *Inhalant-Induced Disorders

292.89	Inhalant Intoxication
292.81	Inhalant Intoxication Delirium
292.82	Inhalant-Induced Persisting Dementia

3. Inhalant-Induced Psychotic Disorder:

291.11	With Delusions
292.12	With Hallucinations
292.84	Inhalant-Induced Mood Disorder
292.89	Inhalant-Induced Anxiety Disorder
292.9	Inhalant-Related Disorder NOS

H. Nicotine-Related Disorders

1. Nicotine Use Disorder

305.10	Nicotine Dependence

2. *Nicotine-Induced Disorder

292.0	Nicotine Withdrawal
292.9	Nicotine-Related Disorder NOS

I. Opioid-Related Disorders

1. Opioid Use Disorders

304.00	Opioid Dependence
305.50	Opioid Abuse

2. *Opioid-Induced Disorders

292.89	Opioid Intoxication
292.0	Opioid Withdrawal
292.81	Opioid Intoxication Delirium

3. Opioid-Induced Psychotic Disorder:

292.11	With Delusions
292.12	With Hallucinations
292.84	Opioid-Induced Mood Disorder
292.89	Opioid-Induced Sexual Dysfunction
292.89	Opioid-Induced Sleep Disorder
292.9	Opioid-Related Disorder NOS

J. Phencyclidine (PCP) (or Phencyclidine-Like)-Related Disorders

1. Phencyclidine Use Disorders

304.60	Phencyclidine Dependence
305.90	Phencyclidine Abuse

2. *Phencyclidine-Induced Disorders

292.89	Phencyclidine Intoxication
292.81	Phencyclidine Intoxication Delirium

3. Phencyclidine-Induced Psychotic Disorder:

292.11	With Delusions
292.12	With Hallucinations
292.84	Phencyclidine-Induced Mood Disorder
292.89	Phencyclidine-Induced Anxiety Disorder
292.9	Phencyclidine-Related Disorder NOS

K. Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

1. Sedative, Hypnotic, or Anxiolytic Use Disorders

304.10	Sedative-, Hypnotic-, or Anxiolytic Dependence
305.40	Sedative-, Hypnotic-, or Anxiolytic Abuse

2. *Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders

292.89	Sedative-, Hypnotic-, or Anxiolytic Intoxication
292.0	Sedative-, Hypnotic-, or Anxiolytic Withdrawal
292.81	Sedative-, Hypnotic-, or Anxiolytic Intoxication Delirium
292.81	Sedative-, Hypnotic-, or Anxiolytic Withdrawal Delirium
292.82	Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia
292.83	Sedative-, Hypnotic-, Anxiolytic-Induced Persisting Amnestic Disorder

3. Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder

292.11	With Delusions
292.12	With Hallucinations
292.84	Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
292.89	Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
292.89	Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction
292.89	Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder
292.9	Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS

L. Polysubstance-Related Disorder

304.80 Polysubstance Dependence

M. Other (or Unknown) Substance-Related Disorders (e.g., anabolic steroids, nitrous oxide)

1. Other (or Unknown) Substance Use Disorders
    - 304.90 Other (or Unknown) Substance Dependence
    - 305.90 Other (or Unknown) Substance Abuse

2. *Other (or Unknown) Substance-Induced Disorders
    - 292.89 Other (or Unknown) Substance Intoxication
    - 292.0 Other (or Unknown) Substance Withdrawal
    - 292.81 Other (or Unknown) Substance-Induced Delirium
    - 292.82 Other (or Unknown) Substance-Induced Persisting Dementia
    - 292.83 Other (or Unknown) Substance-Induced Persisting Amnestic Disorder

3. Other (or Unknown) Substance-Induced Psychotic Disorder:
    - 292.11 With Delusions
    - 292.12 With Hallucinations
    - 292.84 Other (or Unknown) Substance-Induced Mood Disorder
    - 292.89 Other (or Unknown) Substance-Induced Anxiety Disorder
    - 292.89 Other (or Unknown) Substance-Induced Sexual Dysfunction
    - 292.89 Other (or Unknown) Substance-Induced Sleep Disorder
    - 292.9 Other (or Unknown) Substance-Related Disorder NOS

5. *Schizophrenia and Other Psychotic Disorders

Schizophrenia and Other Psychotic Disorders are a constellation of signs and symptoms associated with marked cognitive, social or occupational dysfunction, and marked impairment of reality testing.

A. Schizophrenia: (if duration 1 year +, specify course)

Symptoms of Schizophrenia include: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior - continuous symptoms for at least 6 months.

295.10	Disorganized Type
295.20	Catatonic Type
295.30	Paranoid Type
295.60	Residual Type
295.90	Undifferentiated Type

B. 295.40 Schizophreniform Disorder (specify if with or without good prognostic features)*

Symptoms of Schizophreniform Disorder are the same as for Schizophrenia, but the duration is 1-6 months - impaired social or occupational functioning are not necessarily present.

C. 295.70 Schizoaffective Disorder (specify if bipolar or depressive type)*

Schizoaffective Disorder is defined as an uninterrupted period of illness in which there is a Major Depressive, Manic, or Mixed Episode concurrent with symptoms of Schizophrenia.

D. 297.1 Delusional Disorder (specify type: erotomanic, grandiose, jealous, persecutory, somatic, mixed, unspecified)

Delusional Disorder is the presence of 1 or more non-bizarre delusions persisting for at least 1 month.

E. *298.8 Brief Psychotic Disorder (specify with or without marked stressors or with postpartum onset)

Brief Psychotic Disorder is the sudden onset of psychotic symptoms of delusions, hallucinations, disorganized speech or grossly disorganized or catatonic behavior of at least 1 day, but less than 1 month.

F. 297.3 Shared Psychotic Disorder (Folie a Deux)

Shared Psychotic Disorder is defined as a delusion that develops in a person who is in a close relationship with another person who has a psychotic disorder with delusions.

G. *Psychotic Disorder Due to . . . (Indicate the General Medical Condition)

This disorder is defined as a psychotic disorder resulting from a medical condition.

293.81	With Delusions
293.82	With Hallucinations

H. *-.- Substance-Induced Psychotic Disorder (code based on specific substance)

This disorder is defined as a psychotic disorder resulting from the use of a substance.

I. 298.9 Psychotic Disorder NOS

6. Mood Disorders

Major symptom is a depressed mood, including feeling sad, hopeless, discouraged, "down in the dumps".

Specifiers:
- melancholic features
- atypical features
- catatonic features
- rapid cycling
- seasonal pattern
- postpartum onset
- with or without inter-episode recovery

A. Depressive Disorders

296.xx Depressive Disorders are defined as 1 or more major depressive episodes with depressed mood and other depressive symptoms for at least 2 weeks.

1. Major Depressive Disorder: The essential feature is a period of at least 2 weeks with either depressed mood or loss of interest or pleasure in nearly all activities. In children or adolescents, the mood may be irritable rather than sad. At least 4 other symptoms must be present: changes in appetite or weight, sleep, psychomotor activity; decreased energy, feelings of worthlessness or

guilt; difficulty thinking, concentrating or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. Symptoms must be new or clearly worse than before the episode. Symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must include clinically significant distress or impairment in social, occupational, or other important areas of functioning or needing markedly increased effort in functioning. Specify severity - Replace x with current state of disorder: 0 unspecified, 1 mild, 2 moderate, 3 severe without psychotic features, 4 severe with psychotic features, 5 in partial remission, 6 in full remission.
296.2x Single Episode

2. 296.3x Recurrent
311 Depressive Disorder NOS

3. 300.4 Dysthymic Disorder (specify if early or late onset, with atypical features)
Dysthymic Disorder is defined as 2 years of depressed mood on more days than not which do not meet the criteria for Major Depressive Episode. Dysthymic Disorder is chronic, with less severe depressive symptoms that have been present for many years. It can be diagnosed following Major Depressive Disorder only if it was established prior to the first Major Depressive Disorder or there has been a full remission of the Major Depressive Disorder.

B. Bipolar Disorders

1. *296 Bipolar I Disorder: (specify severity, other features) - 1 or more Manic or Mixed Episodes usually with a Major Depressive Episode.

A Manic Episode is a period of time (usually at least 1 week) of abnormally and persistently elevated, expansive, or irritable mood with symptoms such as inflated self-esteem or grandiosity, decreased need for sleep, over-talkativenss or pressured speech, flight of ideas, racing thoughts, inattentiveness and distractibility.

A Hypomanic Episode is similar to a Manic Episode except it is not as severe and would not cause marked impairment in social or occupational functioning or hospitalization.
296.0x Single Manic Episode
296.40 Most Recent Episode Hypomanic
296.4x Most Recent Episode Manic
296.5x Most Recent Episode Depressed
296.6x Most Recent Episode Mixed
296.7 Most Recent Episode Unspecified

2. 296.89 Bipolar II Disorder (Recurrent major depressive episodes with at least 1 Hypomanic Episode) (Specify current or most recent episode, severity, other features)
3. 301.13 Cyclothymic Disorder - at least 2 years of many periods of hypomanic symptoms and depressive symptoms
4. 296.80 Bipolar Disorder NOS

C. Other Mood Disorders

1. * 293.83 Mood Disorder Due to . . . (Indicate the General Medical Condition) (specify type of mood disorder)
2. * -.- Substance-Induced Mood Disorder (code based on specific substance)
3. 296.90 Mood Disorder NOS

7. Anxiety Disorders

Disorders precipitated by intense fear and distress, characterized by feelings of anxiety. Panic Attacks (not codable alone) consist of a period of intense fear or discomfort with 4 or more physical symptoms or intense fears.

Agoraphobia is defined as anxiety about being in places or situations in which escape might be difficult or embarrassing or in which help may not be available should a panic attack occur. It is usually typified by a fear of going into the open, of leaving one's home or of being in a crowd, standing in line, or traveling in a car or train.

A.	300.01	Panic Disorder Without Agoraphobia
B.	300.21	Panic Disorder With Agoraphobia
C.	300.22	Agoraphobia Without History of Panic Disorder
D.	*300.29	Specific Phobia (formerly Simple Phobia) (specify type: animal, natural environment, blood/injection/injury, situational, other)*
E.	*300.23	Social Phobia (formerly Social Anxiety Disorder) (specify if generalized type)* (subsumes Avoidant Disorder of Childhood)*
F.	300.3	Obsessive-Compulsive Disorder (specify if with poor insight)*
G.	*309.81	Posttraumatic Stress Disorder (specify if acute or chronic, and with delayed onset)
H.	*308.3	Acute Stress Disorder (new)
I.	300.02	Generalized Anxiety Disorder (includes Overanxious Disorder of Childhood)*
J.	293.84	Anxiety Disorder Due to . . . (Indicate the General Medical Condition) (specify if with generalized anxiety, panic attacks, or obsessive-compulsive symptoms)
K.	*-.-	Substance-Induced Anxiety Disorder (code based on specific substance)
L.	300.00	Anxiety Disorder NOS

8. Somatoform Disorders

Somatoform Disorders are the presence of actual or perceived physical symptoms not fully explained by a general medical condition, by direct effects of a substance, or another mental disorder

A.	*300.81	Somatization Disorder
B.	*300.82	Undifferentiated Somatoform Disorder
C.	300.11	Conversion Disorder (specify type of symptom or deficit: motor, sensory, seizures or convulsions, mixed)
D.	*307.80	Pain Disorder Associated with Psychological Factors (formerly Somatoform Pain Disorder) (specify if acute or chronic)
E.	*307.89	Pain Disorder Associated with Both Psychological Factors and a General Medical Condition
F.	300.7	Hypochondriasis (specify if with poor insight)*
G.	300.7	Body Dysmorphic Disorder
H.	300.82	Somatoform Disorder NOS

9. Factitious Disorders

Factitious Disorders are physical or psychological symptoms intentionally produced or feigned so as to put oneself in the role of being sick or taken care of.

A. *300.16 Factitious Disorder With Predominantly Psychological Signs and Symptoms
B. *300.19 Factitious Disorder With Predominantly Physical Signs and Symptoms
C. *300.19 Factitious Disorder With Combined Psychological and Physical Signs and Symptoms
D. 300.19 Factitious Disorder NOS

10. Dissociative Disorders

Dissociative Disorders are defined as the sudden, gradual, transient or chronic disruption of the integrated functions of consciousness, memory, identity, or perception of the environment.

A. *300.12 Dissociative Amnesia (formerly Psychogenic Amnesia)
B. *300.13 Dissociative Fugue (formerly Psychogenic Fugue)
C. *300.14 Dissociative Identity Disorder (formerly Multiple Personality Disorder)
D. 300.6 Depersonalization Disorder
E. 300.15 Dissociative Disorder NOS

11. Sexual and Gender Identity Disorders

Sexual and Gender Identity Disorders are disturbances in sexual desire and the psychophysiological changes characterizing the sexual response cycles and which cause distress and interpersonal difficulty.

A. **Sexual Dysfunctions** (specify due to psychological factors or due to combined psychological factors and a general medical condition; lifelong or acquired; generalized or situational)*

1. Sexual Desire Disorders
    a. 302.71 Hypoactive Sexual Desire Disorders
    b. 302.79 Sexual Aversion Disorder

2. Sexual Arousal Disorders
    a. 302.72 Female Sexual Arousal Disorder
    b. 302.72 Male Erectile Disorder

3. Orgasmic Disorders
    a. *302.73 Female Orgasmic Disorder (formerly Inhibited Female Orgasm)
    b. *302.74 Male Orgasmic Disorder (formerly Inhibited Male Orgasm)
    c. 302.75 Premature Ejaculation

4. Sexual Pain Disorders (not due to a general medical condition)
    a. 302.76 Dyspareunia
    b. 306.51 Vaginismus

5. *Sexual Dysfunctions Due to . . . (Indicate the General Medical Condition)
    a. 625.8 Female Hypoactive Sexual Desire Disorder Due to . . . (Indicate the General Medical Condition)
    b. 608.89 Male Hypoactive Sexual Desire Disorder Due to . . . (Indicate the General Medical Condition)
    c. 607.84 Male Erectile Disorder Due to . . . (Indicate the General Medical Condition)
    d. 625.0 Female Dyspareunia Due to . . . (Indicate the General Medical Condition)
    e. 608.89 Male Dyspareunia Due to . . . (Indicate the General Medical Condition)

f. 625.8 Other Female Sexual Dysfunction Due to . . . (Indicate the General Medical Condition)
g. 608.89 Other Male Sexual Dysfunction Due to . . . (Indicate the General Medical Condition)

6. *-.- Substance-Induced Sexual Dysfunction (code based on specific substance)

7. 302.70 Sexual Dysfunction NOS

B. Paraphilias

Paraphilias are recurrent, intense sexual urges and sexually arousing fantasies that involve nonhuman objects, children or other non-consenting persons, or the suffering or humiliation of oneself or the sexual partner.

1. 302.4 Exhibitionism
2. 302.81 Fetishism
3. 302.89 Frotteurism
4. 302.2 Pedophilia (specify if sexually attracted to males, females, or both; if limited to incest; exclusive or nonexclusive type)
5. 302.83 Sexual Masochism
6. 302.84 Sexual Sadism
7. 302.3 Transvestic Fetishism (specify if with gender dysphoria)*
8. 302.4 Exhibitionism
9. 302.82 Voyeurism
10. 302.9 Paraphilia NOS

C. *Gender Identity Disorders (for sexually mature individuals, specify if sexually attracted to males, females, both, or neither)

Gender Identity Disorders are disorders characterized by a strong and persistent identification with the opposite sex and discomfort with one's assigned sex or a sense of inappropriateness in that gender role.

1. 302.6 Gender Identity Disorder in Children
2. *302.85 Gender Identity Disorder in Adolescents and Adults
3. 302.6 Gender Identity Disorder NOS

D. 302.9 Sexual Disorder NOS

12. *Eating Disorders

Severe disturbances in eating behavior.

A. 307.1 **Anorexia Nervosa** (specify if restricting type or binge eating purging type)*

Anorexia Nervosa is characterized by refusal or inability to maintain minimum normal weight (e.g., 85% of normal body weight) for one's age and height along with intense fears of gaining weight or becoming fat even though underweight. In females, failure to menstruate for at least 3 consecutive cycles (amenorrhea). In the restricting type, the person does not regularly engage in binge eating. In the binge eating/purging (bulimic) type, the person engages in recurrent episodes of binge eating or purging during the episodes of anorexia nervosa.

B. 307.51 **Bulimia Nervosa** (specify if purging or non-purging type)*

Bulimia Nervosa is characterized by recurrent episodes of binge eating followed by compensatory behavior such as purging or other methods to control weight, such as strict dieting, fasting, or vigorous exercise. These persons are able to maintain body weight at or above a minimally normal level.

C. 307.50 Eating Disorder NOS

13. Sleep Disorders

Severe disturbances in sleeping (organized by presumed etiology).

A. *Primary Sleep Disorders (new category)

1. Dyssomnias
   a. 307.42 Primary Insomnia
   b. 307.44 Primary Hypersomnia
   c. *347 Narcolepsy
   d. *780.59 Breathing-Related Sleep Disorder (code medical condition on Axis III)
   e. 307.45 Circadian Rhythm Sleep Disorder (specify if delayed sleep phase type, jet lag type, shift work type, or unspecified)*
   f. 307.47 Dyssomnia NOS

2. Parasomnias
   a. 307.47 Nightmare Disorder
   b. 307.46 Sleep Terror Disorder
   c. 307.46 Sleepwalking Disorder
   d. 307.47 Parasomnia NOS

B. *Sleep Disorders Related to Another Mental Disorder (new category)

1. 307.42 Insomnia Related to . . . (Indicate the Axis I or Axis II disorder)
2. 307.44 Hypersomnia Related to . . . (Indicate the Axis I or Axis II disorder)

C. Other Sleep Disorders *Sleep Disorder Due to . . (Indicate the General Medical Condition):

780.52	Insomnia Type
780.54	Hypersomnia Type
780.59	Parasomnia Type
780.59	Mixed Type
-.-	Substance-Induced Sleep Disorder (specify type) (code based on specific substance)

14. Impulse-Control Disorders Not Elsewhere Classified

Failure to resist an impulse, drive or temptation or perform an act that is harmful to the person or others. The cycle pattern is: generally the person feels an increasing sense of tension or arousal before committing an act, then experiencing pleasure, gratification, or relief when committing the act. Subsequent to the act there may or may not be regret, self-reproach, or guilt. A period of calm ensues, then increased tension or arousal begins again and the cycle is repeated.

A. 312.34 **Intermittent Explosive Disorder**

This disorder consists of aggressive outbursts (assultiveness or destruction of property) that are out of proportion to any evident stressors.

B. 312.32 **Kleptomania**

This Impulse-Control Disorder consists of episodes of stealing objects that are not needed for personal use or for their monetary value.

C. 312.33 **Pyromania**

Pyromania is deliberate and purposeful firesetting on more than one occasion.

D. 312.31 **Pathological Gambling**

Pathological Gambling is characterized by the preoccupation with gambling, planning the next gambling time, scheming or illegal activity to get money to gamble with, gambling with more and more money to get the desired excitement, difficulty or failure to stop gambling, concealing the extent of the involvement in gambling, negative effects on relationships or career because of the focus on gambling.

E. 312.39 **Trichotillomania**

This disorder is pathological hair pulling resulting in noticeable hair loss.

F. 312.30 **Impulse Control Disorder NOS**

15. *Adjustment Disorders (specify if acute or chronic)*

Development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor (s) and must develop within 3 months of the onset of the stressor (s). The symptom must be resolved within 6 months of termination of the stressor(s) or its consequences. If symptoms occur in response to a chronic stressor or a stressor with enduring consequences, the symptoms may last longer than 6 months.

A. *Adjustment Disorder:

309.0	With Depressed Mood
309.24	With Anxiety
309.28	With Mixed Anxiety and Depressed Mood
309.3	With Disturbance of Conduct
309.4	With Mixed Disturbance of Emotions and Conduct
309.9	Unspecified

Axis II

16. Personality Disorders

Long-standing, deeply ingrained, ego-syntonic, maladaptive behaviors, responses and modes of thought. The disorders usually begin by early adulthood, often interfering with normal interpersonal relationships and creating functional impairment and/or subjective distress.

Cluster A: Odd, suspicious, eccentric group

A. 301.0 **Paranoid Personality Disorder**

This personality disorder is characterized by distrust and suspiciousness. Other people's motives are seen as having evil intent.

B. 301.20 **Schizoid Personality Disorder**

This disorder is characterized by detachment from social relationships and restricted emotional expression

C. 301.22 **Schizotypal Personality Disorder**

This is a personality disorder characterized by great discomfort in close relationships, cognitive or perceptual distortions, and eccentric behavior.

Cluster B: Dramatic, emotional, erratic, egocentric group

A. 301.7 **Antisocial Personality Disorder**

This is a personality disorder characterized by disregard for and violation of the rights of others. The person must be at least 18 years of age and may have been diagnosed with Conduct Disorder prior to age 15.

B. 301.83 **Borderline Personality Disorder**

In this personality disorder, the person evidences instability in interpersonal relationships, self-image, affect and impulsivity.

C. 301.50 **Histrionic Personality Disorder**

This is a personality disorder where a person evidences excessive emotionality and attention seeking behaviors.

D. 301.81 **Narcissistic Personality Disorder**

This personality disorder is characterized by grandiosity, need for admiration, and lack of empathy toward others.

Cluster C: Anxious, fearful, indirect group

A. 301.82 **Avoidant Personality Disorder**

Avoidant Personality Disorder is characterized by social inhabition, feelings of inadequacy, and hypersensitivity to negative evaluation or the perception of negative evaluation.

B. 301.6 **Dependent Personality Disorder**

In this personality disorder, the person evidences submissive and clinging behavior and excessive need to be taken care of.

C. 301.4 **Obsessive-Compulsive Personality Disorder**

This personality disorder is characterized by the preoccupation with orderliness, perfection and control resulting in less flexibility, openness and efficiency.

D. 301.9 **Personality Disorder NOS**

AXIS I - NOT MENTAL DISORDERS

17. Other Conditions That May Be a Focus of Clinical Attention

A. 316 ***Psychological Factors Affecting Medical Condition**

These problems may be the focus of therapeutic attention, but do not meet the criteria of a mental disorder.

Choose a name based on nature of factors:

Mental Disorder Affecting . . . (Indicate the General Medical Condition)
Personality Traits (or Coping Style) Affecting . . . (Indicate the General Medical Condition)
Maladaptive Health Behaviors Affecting . . . (Indicate the General Medical Condition)
Stress-Related Physiological Response Affecting . . . (Indicate the General Medical Condition)
Other or Unspecified Factors Affecting . . . (Indicate the General Medical Condition)

B. *Medication-Induced Movement Disorders:

1.	*332.1	Neuroleptic-Induced Parkinsonism
2.	*333.92	Neuroleptic Malignant Syndrome
3.	*333.7	Neuroleptic-Induced Acute Dystonia
4.	*333.99	Neuroleptic-Induced Acute Akathisia
5.	*333.82	Neuroleptic-Induced Tardive Dyskinesia
6.	*333.1	Medication-Induced Postural Tremor
7.	*333.90	Medication-Induced Movement Disorder NOS
8.	*995.2	Adverse Effects of Medication NOS

C. Relational Problems:

*V61.9	Relational Problem Related to a Mental Disorder or General Medical Condition
V61.20	Parent-Child Relational Problem
V61.10	Partner Relational Problem
V61.8	Sibling Relational Problem
V62.81	Relational Problem NOS

D. *Problems Related to Abuse or Neglect (new category):

*V61.21	Physical Abuse of Child (995.54 if attention is on victim)
*V61.21	Sexual Abuse of Child (995.53/victim)
*V61.21	Neglect of Child (995.52/victim)
Physical Abuse of Adult	
V61.12	(if by partner)
V62.83	(if by person other than partner)
Sexual Abuse of Adult	
V61.12	(if by partner)
V62.83	(if by person other than partner)

E. Additional Conditions That May Be a Focus of Clinical Attention:

V15.81	Noncompliance with Treatment
V65.2	Malingering
V71.01	Adult Antisocial Behavior
V71.02	Childhood or Adolescent Antisocial Behavior
V62.89	Borderline Intellectual Functioning (IQ 70-80) (Axis II)
*780.9	Age-Related Cognitive Decline
V62.82	Bereavement
V62.3	Academic Problem
V62.2	Occupational Problem
*313.82	Identity Problem
*V62.89	Religious or Spiritual Problem
*V62.4	Acculturation Problem
V62.89	Phase of Life Problem

F. Additional Codes:

300.9	Unspecified Mental Disorder (nonpsychotic)
V71.09	No Diagnosis or Condition on Axis I
799.9	Diagnosis or Condition Deferred on Axis I
V71.09	No Diagnosis on Axis II
799.9	Diagnosis or Condition Deferred on Axis II

SUMMARY OF KEY CHANGES FROM DSM-III-R

1. Content changes in DSM-IV manual

A. In DSM-IV there is a greater emphasis on biological processes, medical conditions and substance use.
B. Additional qualifiers and specifiers are added to identify diagnoses more specifically.
C. Some qualifiers are changed for clarity.
D. Child disorders now include only those diagnoses that begin in early childhood.
E. Disorders included in the DSM-III-R Organic Mental Disorders section, now are in a Cognitive Disorders group of Delirium, Dementia and Amnestic and Other Cognitive Disorders.
F. DSM-IV includes a recognition of cultural differences and the need to be aware of them.
G. DSM-IV is compatible with ICD-10 codes.
H. DSM-IV includes new or amended appendices including the following:

Appendix B	Criteria Sets and Axes Provided for Further Study
Appendix D	Annotated Listing of Changes in DSM-IV
Appendix G	ICD-9-CM Codes for Selected General Medical Conditions and Medication-Induced Disorders
Appendix H	DSM-IV Classification With ICD-10 Codes
Appendix I	Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes

2. Changes in the multiaxial system

A. Axis I

- Clinical Syndromes
- Other Conditions That May be a Focus of Clinical Attention (now includes Developmental Disorders that were coded on Axis II in DSM-III-R)

B. Axis II

- Personality Disorders
- Mental Retardation (may also include personality traits, defense levels and defense mechanisms - listed on DSM-IV pages 751-753)

C. Axis III

- Physical problems listed must be verified by a physician.
- Use ICD-9-CM codes in Appendix G, or obtain code from a physician.

D. Axis IV

- List Psychosocial and Environmental Problems - no code number is included. A code number was needed in DSM-III-R.

E. Axis V

- Expanded Global Assessment of Functioning (GAF) Scale from 1 - 100. Proposed Axes for Further Study may be used in addition to the GAF scale.
- Global Assessment of Relational Functioning (GARF) Scale

- Social and Occupational Functioning Assessment Scale (SOFAS). Cultural Formulation may also be used.

3. Changes in diagnostic categories

A. Disorders that were deleted from DSM-III-R or are now subsumed under other DSM-IV categories

1. Child Disorders

Cluttering - deleted; now code under Communication Disorders
Overanxious Disorder of Childhood - deleted; now code under Generalized Anxiety Disorder
Avoidant Disorder of Childhood - now code under Social Phobia
Undifferentiated Attention-Deficit Disorder - deleted; now code under Attention-Deficit/Hyperactivity Disorder
Identity Disorder - now under Identity Problem - V code
  Gender Identity Disorder of Childhood
  Gender Identity Disorder of Adolescence, Nontranssexual Type
  Transsexualism - Now code these Gender disorders under Gender Identity Disorder which is placed in the "adult" Sexual and Gender Identity Disorders Section

2. Adult Disorders

Idiosyncratic Alcohol Intoxication - deleted; now code under Alcohol Intoxication
Passive Aggressive Personality - deleted; now code under Personality Disorder NOS
Psychological Factors Affecting Physical Condition - now use V code

B. New Disorders Introduced Into DSM-IV (Excluding Other Conditions That May Be a Focus of Clinical Attention)

1. Child Disorders

Rett's Disorder - under Pervasive Developmental Disorders
Childhood Disintegrative Disorder - under Pervasive Developmental Disorders
Asperger's Disorder - under Pervasive Developmental Disorders
Feeding Disorder of Infancy or Early Childhood - not under another disorder

2. Adult Disorders

Delirium Due to Multiple Etiologies
Dementia Due to Multiple Etiologies
Catatonic Disorder Due to a General Medical Condition
Bipolar II Disorder
Acute Stress Disorder
Sexual Dysfunction Due to a General Medical Condition
Narcolepsy
Breathing-Related Sleep Disorder
Culture-Bound Syndromes (no code number)

3. New V Codes

Medication Induced Movement Disorder
Relational Problems
Problems of Abuse and Neglect

10 STEPS TO DIAGNOSIS

The central task of diagnosis is the identification of the major problem. The therapist must listen for the client's presentation of his/her concerns and ask progressively defining questions. For example, someone comes to see the therapist and begins to speak in a very quiet voice, almost whispering. The therapist asks if there is a reason the person is talking so softly. The person may answer "Yes, I'm afraid people outside the office will hear me."

1. Identification of major problem

A. Begin to mentally go through the decision tree
B. What appears to be the major problem? (Ex: suspiciousness)
C. What diagnostic categories share the major characteristic(s)?

2. Begin list #1 (possible diagnosis) e.g.:

A. Substance-Induced Disorder
B. Schizophrenia
   1. Paranoid type
C. Delusional Disorder
D. Dementia
E. Major Depressive Disorder with Psychotic Features
F. Personality Disorder
   1. Borderline
   2. Paranoid

3. Begin list #2 (excluded disorders) e.g.:

A. Anxiety Disorders
B. Somatoform Disorders
C. Sexual Disorders
D. Sleep Disorders
E. Factitious Disorders
F. Impulse Control Disorders
G. Adjustment Disorders

4. Narrow the diagnostic focus

A. Determine Precipitating Factors
  1. Psychosocial factors
  2. Environmental factors

B. Determine Overall Pattern of Problem
  1. Lifelong
  2. Episodic
    a. Duration
    b. Frequency
  3. Degree of severity

5. Modify lists of possible and excluded diagnoses

A. Shorten list #1 - possible diagnoses
B. Add to #2 - rejected diagnoses
C. Begin list #3 - possible diagnoses, not yet checked out

6. Continue to ask questions about each possible diagnosis

7. If the pattern appears lifelong, concentrate on Axis II disorders

8. If the pattern appears episodic or is one-time only, concentrate on Axis I disorders

9. Continue to adjust lists 1, 2, & 3 by using:

A. descriptive information about the problem
B. frequency of problem
C. duration of problem

10. Diagnosis of problem

*(adapted from Othmer & Othmer, 1994)

CHAPTER 5

Treatment Planning

Although managed care companies and some insurance companies focus on short-term therapy, often using Behavioral or Cognitive-Behavioral techniques, it is important to note that Psychodynamic techniques are also used in brief therapy, using very specific, goal oriented treatment plans. Longer-term needs of clients, including affective and intrapsychic issues, that are relevant to problems of the client are addressed in this manual as well as the short-term needs. With all clients, the development of, and active involvement in, community and family support systems should be encouraged when possible.

NOTE: Any part of the treatment planning process that seems difficult has been explained in more detail.

AXIS I

CLINICAL DISORDERS AND OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

1. Disorders usually first diagnosed in infancy, childhood, or adolescence

A. Mental Retardation: (code on Axis II)

Mental Retardation must be documented by an individual IQ test, usually a Stanford Binet or one of the Wechesler family of tests (WISC or WAIS) and an assessment of adaptive functioning.

1. **Theoretical approach:** Behavior Therapy, Play Therapy, Family Therapy

2. **Treatment techniques:** In treating persons with Mental Retardation, there are actually two clients: 1) the Mentally Retarded person and 2) the family of the Mentally Retarded person. Treatment must deal with both. Modified counseling techniques are used. The sessions should be structured, active, and directive. The therapist may use props, games, pictures, or may take walks.

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The sessions may need to be shortened to one-half hour. Sessions focus on self-esteem, interpersonal relations and self-care. In working with the family, the focus on family issues of loss, grieving, and maintaining healthy dynamics within the family is needed. Decisions may need to be made involving education and residential placement. Siblings of the mentally retarded person are often overlooked, ignored or expected to be "perfect" and may even often "look perfect". In counseling, however, they may be found to be angry, depressed, and disappointed. Family and teachers may need to be taught particular behavior modification programs that include clear expectations and guidelines as well as help to follow the program.

B. Learning and Behavior Disorders

1. Learning Disorders
2. Motor Skills Disorder
3. Communication Disorders
4. Pervasive Developmental Disorders
5. Attention-Deficit and Disruptive Behavior Disorders
6. Feeding and Eating Disorders of Infancy or Early Childhood
7. Tic Disorders
8. Elimination Disorders
9. Other Disorders of Infancy, Childhood, or Adolescence

a. **Medication:** Medication may be used particularly with Attention-Deficit and Disruptive Behavior Disordered clients. However, counseling should be tried first, and only later, if counseling is not successful, should a referral for a medication consultation be made. If medication, usually Ritalin, is prescribed, it should be closely monitored by the therapist.

b. **Theoretical approach:** Behavioral, Cognitive-Behavioral, Psychodynamic, Play Therapy, Reality Therapy, Family Therapy, Parent Training Programs.

c. **Treatment techniques** for these disorders are similar to those of mental retardation; these include the need to structure the counseling sessions to be active, to use props, games, and pictures to help the client better express her/himself. Taking walks, shortening the sessions to one-half hour, listening closely to the client and taking particular note of interests and responses are all very important with these clients. Play Therapy is used with younger children to enable them to express how they feel about themselves and their environment. This technique allows the therapist to understand the client's personality structure and to treat the problems the client is having about her/himself in relation to others. It is important to set up Behavior Modification programs that are do-able and that can be carried out in all appropriate settings. Working with school personnel should be part of the therapeutic approach. With older children Reality Therapy or Psychodynamic Therapy is used. Family involvement is vital in order for the therapeutic work to continue into the home. Appropriate parent training programs should be considered. Family therapy is used, focusing on loss, grief, and the maintenance of healthy family dynamics. The parent or parents may need counseling to help with their own feelings of guilt. Families may also need help with interfacing with the community or school with regard to the client. In their literature review, Roth & Fonagy (1996) note that: "The appropriate therapy depends on the form and severity of presentation, though more structured interventions based on theoretical models appear more effective than generic counseling" (p. 367). Specifically, they found the following interventions to be most helpful with children:

- Behavior modification for enuresis and encopresis
- Parent training programs and cognitive-behavioral therapy for oppositional behavior
- Rapid exposure for school phobia
- Cognitive-behavioral treatment for GAD (Generalized Anxiety Disorder) (promising/limited effectiveness)
- Psychodynamic psychotherapy for GAD (promising/limited effectiveness)
- Exposure and response prevention for OCD (promising/limited effectiveness)
- Structural family therapies for disruptive disorders (promising/limited effectiveness)
- Long-term multimodal therapy for ADHD (promising/limited effectiveness)
- Family therapy for psychophysiological disorders
- Psychodynamic psychotherapy for psychophysiological disorder (promising limited effectiveness)
- Contingency management treatment of undesirable behavior in pervasive developmental disorders (Roth & Fonagy, 1996, p. 367)

2. Delirium, Dementia, and Amnestic and Other Cognitive Disorders:

In this group of disorders, safety of the client is paramount.

A. **Delirium** is a "disturbance of consciousness and a change in cognition that develop over a short period of time" (DSM-IV, p. 123). It is a medical emergency and safety of the client is the first priority.

1. **Medication:** Haloperidol is often used for the agitation.

2. **Theoretical approach:** Psychoeducational, Cognitive

3. **Treatment techniques:** These clients should be followed closely by a neurologist and a psychiatrist. The psychotherapist may not be the primary treatment person, since the client's medication and safety needs may take precedence. Psychological support during and after a delirium is important. Counseling is very structured and is focused particularly on helping the client understand the bizarre experience, helping her/him talk about it (if the client remembers it). Explanation and education helps reduce the likelihood of posttraumatic symptoms. Explanation to the family about delirium helps reduce anxiety and calm fears.

B. **Dementia** is a syndrome that includes both deterioration of intellectual ability and alterations in the client's emotional and personality functions. The causes are Alzheimer's disease, vascular dementia, general medical conditions or multiple etiologies.

1. **Medication** is usually directed toward the particular symptoms.

2. **Theoretical approach:** Psychoeducational, Cognitive-Behavioral, Psychodynamic

3. **Treatment techniques:** These clients also should be followed closely by a neurologist and a psychiatrist. Again, the psychotherapist may not be the primary treatment person. Teaching strategies for enhancing memory can help. Working with the client regarding the feelings of loss of cognitive faculties is also important.

C. **Amnestic Disorders** are characterized by disturbances in memory caused by the direct effects of a general medical condition or the persisting effects of a substance. The substance may be a drug of abuse, medication, or a toxin.

1. **Medication:** None is prescribed for this disorder.

2. **Theoretical approach:** No approach has been shown to be consistently successful. Cognitive-Behavioral Therapy has had some success.

3. **Treatment techniques:** The use of a real-life, problem-oriented approach may help in teaching these clients particular strategies for enhancing memory or working around memory gaps. Use of external aids to solve the problems of everyday life, including use of a memory book, keeping a daily calendar or memory board have been tried. Teaching clients to remember to use the aids (prospective memory) is another problem not yet completely resolved. Targeting treatment to the underlying etiology of the disturbance is important.

3. Mental Disorders Due To a General Medical Condition

Some mental disorders are the direct consequence of a medical condition. The medical condition, itself, must be coded on Axis III. Disorders included are:

- Catatonic Disorder Due to a General Medical Condition
- Personality Change Due to a General Medical Condition
- Mental Disorder Not Otherwise Specified Due to a General Medical Condition (incl.: Mental Disorder Not Otherwise Specified Due to HIV Disease)

A. **Medication:** may be prescribed for the physical condition and psychotropic medication may be needed.

B. **Theoretical approach:** Cognitive-Behavioral, Psychodynamic

C. **Treatment techniques:** The client should be followed closely by a physician. Psychotherapy should include coping with the medical condition and behaviors that may need to be changed. The client may also need to deal with feelings of loss surrounding the medical condition and responses to the client by family, friends or the general public.

4. Substance-Related Disorders including:

- Alcohol-Related Disorders
- Amphetamine-Related Disorders
- Caffeine-Related Disorders
- Cannabis-Related Disorders
- Cocaine-Related Disorders
- Hallucinogen-Related Disorders
- Inhalant-Related Disorders
- Nicotine-Related Disorders
- Opioid-Related Disorders
- Phencyclidine-Related Disorders (PCP)
- Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

A. **Medication:** may be used, particularly during detoxification.

B. **Theoretical approach:** Psychoeducation, Behavioral, Cognitive, Group, Family, Psychodynamic

C. **Treatment techniques:** Found most effective: behavioral therapy aimed at increasing social adaptation including social skills training, marital therapy, and community reinforcement packages as well as brief educational interventions, including motivational interviewing, (Roth & Fonagy, 1996). Also used are: group counseling, participation in AA/NA, and family counseling to help support changes. Individual counseling helps the client integrate all the aspects of the other therapeutic interventions. See section on Substance Use Disorders in this manual.

5. Schizophrenia and Other Psychotic Disorders

A. Schizophrenia

1. **Medication:** Medication is the primary mode of treatment, usually a neuroleptic for the psychotic symptoms. Consistent medical management is necessary.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral, Group, Psychodynamic, Family

3. **Treatment techniques:** Family intervention programs are found to be the most effective treatment (Roth & Fonagy, 1996). The psychotherapist works with family members to help them understand the nature of the disorder and assists them in moderating their own behavior (particularly criticism) to reduce the possibility of a recurrence or relapse. Cognitive therapy has been found effective for delusions. Individual therapy is used and is supportive to help the client deal with skills of daily living and increase social skills. Emphasis on medication compliance is important.

B. Schizophreniform Disorder

1. **Medication:** Use depends on the severity and duration of the episode as well as other factors such as: risk of suicide or homicide, previous episodes, family history, premorbid level of functioning. Neuroleptic medication is used. Medication is the primary mode of treatment.

2. **Theoretical approach:** Psychoeducation, Family, Group (however, if client is concerned about prognosis, he/she may become frightened in a group if chronic schizophrenic clients are participating)

3. **Treatment techniques:** Treatment of the acute symptoms of Schizophreniform Disorder is the same as treatment of the acute symptoms of Schizophrenia. Psychoeducation is focused on the disorder and the necessity of maintenance of neuroleptic medication. This disorder lasts for at least 1 month but less than 6 months. If symptoms persist after 6 months, the diagnosis changes to Schizophrenia.

C. Schizoaffective Disorder

1. **Medication:** Management of the acute phase usually consists of neuroleptic medication for the psychotic symptoms, lithium or another mood stabilizer for the manic or mixed symptoms, and an antidepressant for depressive symptoms. Ongoing medication management is often unclear.

usually focused on the target symptoms and what is judged to be helpful for a particular client. Medication is the primary mode of treatment.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral, Family

3. **Treatment techniques:** The techniques used with these clients depend upon whether the disorder is in the schizophrenic or the affective phase. Psychoeducation focuses on identification of early symptoms, reduction of stress and medication compliance. Focus on daily living and social skills is important as well as helping the client and family understand and cope with the disorder.

D. Delusional Disorder

1. **Medication:** Neuroleptic medication is usually used for the delusions along with an antidepressant if prominent mood symptoms are also present.

2. **Theoretical approach:** Cognitive

3. **Treatment techniques:** Gentle probing of the client's delusional thinking sometimes results in improved reality testing. Confrontation may impair the therapeutic relationship, increase anxiety and promote further decompensation. However, not confronting the delusional thinking can result in the client thinking the therapist believes the fears are real, thus making the client more frightened. Medication compliance is important to stress.

E. Brief Psychotic Disorder

1. **Medication:** Neuroleptics are used for the psychotic symptoms. Medication is the primary mode of treatment, initially. Duration of medication once the psychotic symptoms have subsided varies depending on such issues as: duration and severity of symptoms, presence of suicidal or homicidal impulses, likelihood of response to early signs of relapse, the possibility of the presence of a mood disorder.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral

3. **Treatment techniques:** Supportive psychotherapy focuses on helping the client cope with, or be removed from, the stressor, if there is one. There should be an emphasis on ways in which life-style changes may be helpful in preventing a recurrence. The duration of this disorder is at least one day, but less than one month. If the symptoms persist beyond one month, the diagnosis is Schizophreniform, if there is no mood disorder apparent. If a mood disorder is apparent, the diagnosis is either Bipolar Disorder or Schizoaffective Disorder.

F. Shared Psychotic Disorder (Folie a Deux)

1. **Medication** is generally used only if there is psychotic ideation, at which point medication for the specific psychosis is prescribed.

2. **Theoretical approach:** Cognitive-Behavioral, Psychodynamic

3. **Treatment techniques:** Treatment usually involves coupling treatment of the inducer's disorder, using standard methods, and separation of the dyadic partners. If the delusional beliefs do not diminish in intensity or disappear, upon separation, another diagnosis should be considered. If the person with this disorder is a child, separation may involve a foster care placement or

otherwise transferring dependencies. Encouraging autonomy and independence in both partners is important, particularly if separation is not possible.

G. Substance-Induced Psychotic Disorder

1. **Medication:** Hospitalization may be necessary in the acute stage. Neuroleptic medication is often necessary on a short-term basis.

2. **Theoretical approach:** If there is no major psychiatric illness, treatment of the substance is appropriate (Psychoeducation, Behavior, Cognitive, Group, Family, Psychodynamic). If there is concomitant major psychiatric illness (Dual Dianosis), Psychoeducation and Cognitive-Behavioral approaches are used.

3. **Treatment techniques:** Dealing with the inducing substance is the first priority, followed by attention to the possible risks associated with the psychotic beliefs. The therapist must prevent clients from hurting themselves or others in response to the psychotic thinking. The client must be removed from the environment in which substances are available.

   Dual Diagnosis refers to the coexistence of a major psychiatric illness and substance dependence and/or abuse.

   If the client falls into the Dual Diagnosis category (if there is truly a major psychiatric illness in addition to the substance abuse), effective treatment must address both the medical and psychiatric needs, as well as the client's social and material needs. Case management of a system of treatments and supports is helpful. Substance Abuse programs, in general, may not be appropriate since these clients may be too vulnerable to regression and relapse.

6. Mood Disorders

A. Major Depressive Disorder

1. **Medication:** Antidepressants, MAO inhibitors. Hospitalization may be necessary. With Psychotic Features: antipsychotics in combination with antidepressants

2. **Theoretical approach:** Found to be most effective: Cognitive-Behavioral and Interpersonal. Psychodynamic is also used with some success.

3. **Treatment techniques:** Psychotherapy is the major treatment with clients who exhibit mild or moderate symptoms. The focus of the therapy is to help clients change their disordered thinking and behavior. Techniques of interpersonal therapy help to enhance the social functioning of these clients. Pharmacotherapy may provide rapid, relief from acute distress, while psychodynamic therapy provides broad and enduring change. Psychotherapy combined with medication retains the specific benefits of each, and is used successfully, particularly with severely depressed clients.

   With Melancholic Features: May need treatment for somatic symptoms, using reality-testing and connecting the symptoms with the anxiety/stress.

B. Dysthymic Disorder

1. **Medication:** Antidepressants may be used, although the response is lower than for clients with most other Mood Disorders.

2. **Theoretical approach:** Cognitive-Behavioral, Psychodynamic, Interpersonal

3. **Treatment techniques:** The combination of medication and psychotherapy may be helpful with this group of clients. Other treatment techniques are similar to those with Major Depressive Disorder.

C. Bipolar I Disorder

". . . a clinical course that is characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. Often individuals have also had one or more Major Depressive Episodes" (DSM-IV, pp. 350–351).

1. **Medication:** Mood-stabilizing medication is used, particularly Lithium, which needs to be monitored closely. Lithium may also predispose the client to manic episodes and rapid cycling which would indicate use of alternative mood-stabilizing medication (Gabbard, 1996).

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral

3. **Treatment techniques:** Treatment consists of treating the acute mania, and acute depression, prevention of manic and depressive recurrence. This disorder is almost always recurrent. The therapeutic alliance with these clients is essential. Providing explicit detailed instructions and education about the illness and its treatment, and discussing the anticipated problems in management will help establish this alliance. Charting mood, sleep patterns and treatment on a daily basis and incorporated into a monthly chart is helpful. A treatment plan for each phase of the illness, agreed to by both client and therapist is important.

D. Bipolar II Disorder

". . . a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode. . . . the presence of a Manic or Mixed Episode precludes the diagnosis of Bipolar II Disorder" (DSM-IV, p. 359) (and is then diagnosed as Bipolar I Disorder).

1. **Medication:** Mood-stabilizing medications may be needed on a maintenance regimen. Antidepressants should be used cautiously since a manic episode may develop and/or the client may develop rapid cycling.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral

3. **Treatment techniques:** Clients and families should receive psychoeducation about the nature of the disorder. Cognitive-Behavioral techniques should include training in life-stabilizing techniques and recognizing any early signs of relapse.

E. Cyclothymic Disorder

1. **Medication:** Mood-stabilizing medications and/or antidepressants are often used.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral

3. **Treatment techniques:** Psychoeducational techniques, focusing on encouraging the client to lead as stable a life as possible and to avoid substance use, are helpful. Stability and avoidance of

substance use helps with any internal mood swings, keeping the external world as stable and predictable as possible. Cognitive-Behavioral techniques can also be helpful in maintaining stabilization.

F. Mood Disorder Due to a General Medical Condition

1. **Medication:** Medication for the General Medical Condition may be necessary. Use of an antidepressant or mood-stabilizer may be needed for affective symptoms.

2. **Theoretical approach:** Cognitive-Behavioral, Psychodynamic (particularly Interpersonal), Behavioral Therapy

3. **Treatment techniques:** Many depressive states in clients with medical problems are *not* actually symptoms due to the direct physiological effects of an underlying general medical condition, but may occur *concomitantly* with the medical condition. Those clients should be treated under the appropriate affective diagnosis. The present diagnosis is used only when the mood symptoms are the *direct consequence* of the general medical condition and are clinically significant, such as: fibromyalgia, Huntington's Disease, multiple sclerosis, anorexia nervosa, schizophrenia, HIV, diabetes, brain tumor, stroke, coronary heart disease, asthma, sleep apnea, arthritis. Treatment of the mood symptoms in this disorder are similar to treatment of mood disorders in other diagnoses: focus on disordered thinking and behavior as well as any interpersonal problems.

G. Substance-Induced Mood Disorder

1. **Medication:** With agitated clients, a benzodiazepine may be helpful to control the agitation. If psychosis persists more than 24 hours, a low dose neuroleptic may be necessary. Some psychoses may remit spontaneously following cessation of the drug use. Psychopharmacological medication may be necessary if the mood or anxiety disorder persists for more than a month.

2. **Theoretical approach:** Psychoeducational, Psychosocial, Cognitive-Behavioral, Psychodynamic

3. **Treatment techniques:** Safety of the client is paramount and hospitalization may be necessary. Initial treatment should be targeted to the Substance Abuse or Dependence. Mood symptoms may be present following detoxification at which time medication and/or psychotherapy is needed, depending on the mood disorder.

7. Anxiety Disorders

It is important to be as integrative as possible regarding the various treatments for this group of disorders.

A. Panic Disorder

1. **Medication:** Tricyclic antidepressants, serotonin reuptake inhibitors, MAO inhibitors, high-potency benzodiazapines, anticonvulsants may by used in some complicated cases.

2. **Theoretical approaches:** Behavioral, Cognitive-Behavioral, Psychoeducation, Psychodynamic

3. **Treatment techniques:** Reduction of client's fears, helping a client to understand her/his physical complaints (may use breathing retraining or relaxation techniques, since hyperventilation is often related to many of the symptoms), helping client with her/his misunderstanding of bodily sensations (Cognitive), desensitization techniques, exposure therapy (Behavioral), generally will reduce a client's fears. Combined antidepressant and behavioral treatment may also be especially effective with these clients. Exploring unconscious triggers of panic symptoms (often fear of separation/abandonment) (Psychodynamic) can be helpful. Couples therapy can be especially helpful in some cases.
   With agoraphobia - necessitates treatment for the avoidant behavior. Cognitive-Behavioral approaches particularly using exposure to the feared situations has been found to be the most effective.

B. Specific Phobia

This disorder often accompanies other (perhaps more severe) psychiatric diagnoses. The clinician should make sure the presenting symptomatology is best categorized as a Specific Phobia rather than as Panic Disorder or another diagnosis.

1. **Medication:** Beta-blockers and benzodiazepines may reduce some symptoms.

2. **Theoretical approaches:** Behavioral, Psychodynamic, Psychoeducation

3. **Treatment techniques:** Behavior therapy, consisting of exposure-based therapy (found to be the most efficacious by Roth & Fonagy, eds., 1996), systematic desensitization, relaxation exercises and participant modeling are generally the treatments of choice for uncomplicated specific phobia. Psychodynamic therapy, Psychoeducation, including support and relaxation exercises, may all diminish fear and anxiety, instill hope and a sense of self-efficacy, and facilitate exposure to avoided situations.

C. Social Phobia

1. **Medication:** MAO inhibitors, benzodiazepines, beta-adrenergic blockers

2. **Theoretical approaches:** Cognitive, Behavioral, Cognitive-Behavioral, Psychodynamic (Interpersonal), Group

3. **Treatment techniques:** Cognitive therapy combined with exposure has been found to be the most effective with these clients (Roth & Fonagy, 1996). Also used are cognitive-behavioral techniques of social skills training and relaxation strategies. Cognitive-behavioral group therapy has been used successfully. Interpersonal therapy, aims to diminish disabling fears and anxieties about social embarrassment, shame and rejection. Interpersonal therapy also helps the client overcome avoidant behaviors and have more successful interpersonal experiences.

D. Obsessive-Compulsive Disorder:

Careful diagnosis is very important since clients may hide their symptoms or symptoms may be complicated by comorbid conditions.

1. **Medication:** SRIs, particularly clomipramine; SSRIs: Prosac, Zoloft, Paxil

2. **Theoretical approaches:** Behavioral, Cognitive, Rational Emotive, Psychodynamic

3. **Treatment techniques:** Exposure and response prevention techniques have been found to be the most successful with clients with OCD (Roth & Fonagy, 1996). These therapies are also used with potent SRIs. Cognitive restructuring and rational emotive therapies in combination with exposure therapy have also been found to be successful. The therapist may decide with the client to use psychotherapy, medication or a combination of the two, depending on the severity of the disorder. Clients with mild or moderate symptoms may benefit from cognitive-behavioral approaches alone. A combination of psychotherapy and medication is usually indicated for clients with moderate to severe symptoms. Relapse is often rapid when potent SRIs are discontinued (Gabbard, 1996).

E. Posttraumatic Stress Disorder:

It is important to assess the client for Panic Disorder and Major Depressive Disorder, since they may coexist with PTSD.

1. **Medication:** Antidepressants, MAOIs

2. **Theoretical approaches:** Psychoeducation, Cognitive-Behavioral, Psychodynamic

3. **Treatment techniques:** Stress reduction therapy in combination with cognitive and exposure techniques and applied relaxation have been found to be successful with clients with PTSD. Structured psychodynamic therapy is also successful (Roth & Fonagy, 1996). The client should be helped to understand his/her present symptoms and others that may be likely to occur, including intrusive thoughts, nightmares, startle reactions and physiological triggers. As these symptoms become less terrifying the client may enable to expect reactions that may then have less impact. Treatment should include not only the above mentioned techniques, but also behavioral exposure. Psychodynamic therapy can include group therapy which can be helpful. It is important to help the client regain a sense of control over her/his life.

F. Acute Stress Disorder

1. **Medication:** Propranolol, clonidine, benzodiazepines (unless there is a history of alcoholism)

2. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic, Hypnosis may be helpful

3. **Treatment techniques:** Treatment is based on a crisis intervention model, focusing on rapid reduction of present symptoms and prevention of later illness. Psychotherapy should begin as soon after the trauma as possible. The opportunity for the client to process the traumatic event(s), assisting him/her in integrating the experience into his/her sense of self and the world, is needed. The therapist needs to be sensitive about the traumatic event(s) and provide the supportive environment needed to cope with the traumatic events. Contextual factors surrounding the similarly affected are used in regular group therapy or in "mini-marathon groups" of about 3 hours per session within structured group meetings. Such groups enable the client to obtain social support in coping with the trauma.

G. Generalized Anxiety Disorder

1. **Medication:** Antidepressants, benzodiazepines

2. **Theoretical approaches:** Cognitive-Behavioral, Behavioral

3. **Treatment techniques:** Cognitive-behavioral therapy has been found to be most successful with these clients (Roth & Fonagy, 1996). Techniques include methods that focus on identifying the cognitive responses that are contributing to anxiety (thoughts, interpretations, meanings, predictions, beliefs), and then systematically questioning whether these cognitions are based on reality. Behavioral techniques used for these clients are: self-monitoring, relaxation, exposure methods (i.e., invivo, imagery-based). Since the anxiety these clients experience is a product of several interacting systems, a combination of these interventions, each targeting different aspects of the system, may offer great benefit. Pharmacotherapy should be considered when symptoms are severe or when psychological interventions are not feasible.

8. Somatoform Disorders

A. Somatization Disorder

1. **Medication:** None is generally used.

2. **Theoretical approaches:** Combination of Psychodynamic, Psychoeducational

3. **Treatment techniques:** These clients are generally difficult to treat. The therapist and physician work together to reassure clients that their physical symptoms are not being ignored, while carefully bringing attention to their emotional problems. The relationship between anxiety and physical symptoms must be addressed. Management of clients with this disorder may be long-term supportive psychotherapy that includes an important sympathetic relationship.

B. Conversion Disorder

1. **Medication:** Amobarbital may be used to alter defenses (esp. repression), to allow relaxation and to facilitate the gathering of more historical information. Medication for any depression may be used.

2. **Theoretical approaches:** Hypnosis (since this disorder tends to occur to people who can be suggested into [and out of] symptoms), Behavioral therapy, Supportive therapy, Physical therapy, Biofeedback, Speech therapy, Environmental Intervention may be helpful. Insight oriented therapies generally are not helpful.

3. **Treatment techniques:** Conversion disorder often occurs because of psychosocial stressors in susceptible persons who have difficulty articulating their distress. Thus the therapist must decode the disguised communication and develop a treatment plan which addresses the specific needs of each client. Environmental stressors and possible concurrent psychiatric disorders must be considered. It is generally helpful to coordinate the various therapeutic modalities, psychotherapies, behavior modification techniques and other therapeutic interventions, while reducing the reinforcement of the symptom and providing a face-saving opportunity for the client to relinquish the symptom.

C. Pain Disorder

1. **Medication:** Anti-inflammatory medication (for mild to moderate and other acute pain), antidepressants, analgesics (for moderate to severe pain), benzodiazepines.

2. **Theoretical approaches:** Behavioral, Cognitive-Behavioral

3. **Treatment techniques:** Operant conditioning is used to reinforce positive ("healthy") behaviors and reduce self-defeating behaviors. Cognitive-Behavioral therapy focuses on identifying and correcting the client's distorted attitudes, beliefs, and expectations; helping her/him become more aware of factors that exacerbate and diminish pain and modifying her/his behavior (cognitive restructuring). Techniques used may be biofeedback, relaxation training, hypnosis, distraction, stress management, activity pacing, sleep management. The therapist may help the client plan strategies for dealing with the pain.

D. Hypochondriasis

1. **Medication:** Antidepressants, Benzodiazepines (temporary)

2. **Theoretical approaches:** Cognitive-Behavioral, Educational, Supportive

3. **Treatment techniques:** Few controlled studies have been done on the most efficacious forms of treatment for these clients. However, some researchers are exploring new ways of treating hypochondriasis on the assumption that this problem is largely learned behavior. The objective of treatment is to replace maladaptive responses or habits with ones that are more adaptive. Reassuring the client of the benign nature of their symptoms along with efforts to correct their misperceptions about anatomy, physiology, and neurology may be helpful. Reassurance must take into account the client's previous experiences, reassurance-seeking behavior, personality factors, and need for a trusting, dependable relationship with the clinician. An understanding of transferential and countertransferential responses that can be used in therapeutic interventions is probably helpful.

E. Body Dysmorphic Disorder

1. **Medication:** Antidepressants (fluoxetine or clomipramine if depression is part of the presentation - also useful if OCD or social phobia coexist as is often the case).

2. **Theoretical approaches:** Cognitive-Behavioral

3. **Treatment techniques:** Treatment may take a relatively long time and dosages of medication may need to be higher than is generally needed for depression. Cognitive-behavioral techniques used may be: exposure therapy, response prevention, self-esteem building, cognitive restructuring, developing coping strategies. These techniques are especially helpful when combined with medication.

9. Factitious Disorders

A. Factitious Disorder (may be called Munchausen Syndrome)

1. **Medication:** Antidepressants may be effective with depressed clients. Neuroleptic medication may be used judiciously.

2. **Theoretical approaches:** Cognitive-Behavioral, Reality, Psychodynamic

3. **Treatment techniques:** Confrontational interventions have been used with limited success. Nonconfrontational treatment also has limitations since some clients feel they are in

life-threatening situations and authoritative interventions are needed immediately. It may be helpful to give the client an opportunity to relinquish his/her factitious disorder or to admit it with "face saving" techniques, such as offering a double-bind situation, or hypnosis or biofeedback. The client may accept these techniques more readily than overt psychotherapy and may feel comfortable talking about significant psychological issues. Psychodynamic therapy can be used with some clients.

B. Factitious Disorders Not Otherwise specified

1. Munchausen Syndrome by Proxy (MSP)

a. **Medication:** None

b. **Theoretical approaches:** The following therapies may be helpful, however there are few outcome studies for this diagnosis. For the person perpetrating the factitious disorder, usually the mother: Behavioral, Family therapy. For the child: Behavioral, Family therapy, Supportive therapy. For both mother and child: Creative treatment plans including Family therapy and Supportive therapy.

c. **Treatment techniques:** The mother is often mandated to psychiatric treatment. Outcome data to predict effectiveness of this mandated treatment is very limited. The child (if old enough) may need individual therapy because of the mother's actions. Treatment intervention necessitates close coordination between multiple agencies. If an older child accuses his/her father of sexual abuse, it is important to remember that there is an increased incidence of false claims of sexual abuse in cases of MSP. The mother often initiates these claims, especially if a divorce is a possibility.

2. Malingering

a. **Medication:** None

b. **Theoretical approaches:** Cognitive-Behavioral, Creative approaches

c. **Treatment techniques:** The secondary gain of some external benefit is usually greater than the secondary costs with these clients. A primary gain is often associated with it as well. Identifying the stressors, cognitive restructuring, identifying the gains and reframing may be helpful. These clients require creative approaches to treatment. Few studies are available which indicate "successful" treatment approaches or techniques. Diagnosis may be difficult even for experienced therapists.

10. Dissociative Disorders

A. Dissociative Amnesia

1. **Medication:** None except for drug-facilitated interviews

2. **Theoretical approaches:** Hypnosis, Cognitive-Behavioral, Supportive, Group

3. **Treatment techniques:** The first priority is to establish safety and stabilize the client, then attempt to take a history of the trauma while assuring the client that he/she *can* remember when

he/she is ready - at the client's own pace without needing to remember all the details or information at one time. *Permissive suggestions* for recall is a very important factor, although hypnosis may be helpful. Help the client to develop an organizing framework for understanding her/his symptoms and an understanding of the treatment process. Help the client return to awareness of her/his identity and general personal circumstances. The client may need to be "grounded", literally, by opening his/her eyes and looking around, touching his/her feet or the floor, breathing deeply, etc. The client may need concrete orientation to time and circumstances. The client may also experience PTSD or DID symptoms which would indicate treatment for those symptoms.

B. Dissociative Fugue

These clients may also present memory disturbances including local and/or generalized amnesia.

1. **Medication:** None except for drug-facilitated interviews

2. **Theoretical approaches:** Hypnosis, Cognitive-Behavioral, Family therapy

3. **Treatment techniques:** Since these clients may have traveled far from home (although rarely), appeals to the local media may not alert the client's significant others. The client may resist uncovering his/her actual identity. Family therapy and social service interventions may be necessary to help resolve the complex issues. Treatment techniques used for Dissociative Amnesia are used with Dissociative Fugue as well.

C. Dissociative Identity Disorder (formerly Multiple Personality Disorder)

1. **Medication:** None has been found to have a specific impact. However, coexisting conditions or needs may indicate the need for medication for particular conditions.

2. **Theoretical approaches:** Psychodynamic, Cognitive, Behavioral, Hypnosis, Family therapy - no one model of treatment provides an ideal guide for all the situations and circumstances the clinician may encounter.

3. **Treatment techniques:** DID is, in itself, controversial. There are also many strongly held and often polarized opinions on treatment. Whether DID should be treated at all is controversial. Treatment may (1) focus on integration of the personalities by resolution of dissociative defenses and structures (strategic integrationalism), (2) attempt to bring about integration, but conduct the therapy based on employing skillful, discrete interventions toward a series of tactical therapeutic objectives (tactical integrationalism) (3) be personality-based where there is a belief that dividedness is not problematic or that the personalities need to be nurtured into health (personality-focused treatments) or (4) behavior based focusing on the belief that management of life activities is most important and integration is a secondary goal (adaptationalism). More than one session per week or one longer than normal session is often needed.

   Treatment recommendations associated with good clinical results include: establishing consistent boundaries; focusing on mastery; client participation in treatment (therapeutic tasks may be assigned on a regular basis); establishing a strong therapeutic alliance; working with an "inaccurate memory" to uncover actual material; working with the separateness and conflict of the "alters" (personalities) to emphasize collaboration, cooperation, empathy, and identification among them to diminish conflicts; using simple and direct sentences; approaching issues slowly;

being evenhanded to all alters and not "playing favorites". Therapy should work toward restoring morale and increasing realistic hope. Pace the therapy so it does not become overwhelming. The clinician must be very responsible and hold the client to high standards of responsibility (when reasonable responsibility is understood). The clinician should be less technically neutral, and exhibit warmth to allow for a latitude of affective expression. Correct cognitive errors by gently creating cognitive dissonance about irrational beliefs (in Gabbard, 1995).

D. Depersonalization Disorder

1. **Medication:** The following medications have been used with some success: antidepressants, clozapine (antianxiety), clonazepam (neuroleptic)

2. **Theoretical approaches:** Cognitive, Psychodynamic, Psychoeducation, Family therapy (particularly with the coexistence of DID), Group therapy

3. **Treatment techniques:** Psychotherapy should focus on symptom exploration, reduction of traumatic memories, client education, and self-work. Techniques used are: education regarding the symptom, its development and available treatment; exploration of possible triggers of episodes. The following are used for symptom reduction: "grounding" or reorienting techniques, distraction techniques, controlled dissociation, creative visualization.

11. Sexual and Gender Identity Disorders

The etiology of some sexual disorders are organic factors, medical disorders or medications prescribed for the medical problem, psychotropic medications or substance use. The presence of any of these conditions informs the treatment planning.

A. Sexual Dysfunctions

1. Hypoactive Sexual Desire Disorder

a. **Medication:** Xanax, Desyrel (other antianxiety medications are less useful because of their possible sexual side effects)

b. **Theoretical approaches:** Psychodynamic, Cognitive-Behavioral

c. **Treatment techniques:** Strategies that focus on increasing sexual desire (libido enhancement) in preparation for lovemaking include client's use of erotic fantasy, reading or looking at explicitly erotic material or lightly stimulating his/her own genitalia. The incorporation of these sexually arousing strategies in conjunction with psychotherapy is a unique feature of the psychodynamically oriented sex therapy approach. Cognitive-behavioral interventions focus on systematic, gradual, in-vivo exposure from client-related to partner-related genital stimulation. Techniques include: dating assignments, sex education, sexual skills training, encouragement of genital stimulation, "stay with the pleasure" assignments.

2. Sexual Aversion Disorder

a. **Medication:** Xanax, DeSyrel (other antianxiety medications are less useful because of their possible sexual side effects).

b. **Theoretical approaches:** Psychodynamic, Cognitive-Behavioral

c. **Treatment techniques:** Psychodynamic approaches focus on the elimination or improvement of the high anxiety, panic or phobic aversions which result in the client's sexual panic states. This approach consists of an integrated amalgam of cognitive-behavioral homework assignments that are used to modify the immediate causes of the client's sexual dysfunction and management of the client's resistances in office sessions. Cognitive-behavioral interventions (as in Hypoactive Sexual Desire) focus on systematic, gradual, in-vivo exposure of the client to partner-related genital stimulation, but in Sexual Aversion Disorder the focus is on that specific aspect of sexual behavior that triggers her/his phobic avoidance or revulsion. Comorbid disorders may also exist with this diagnosis which would need attention.

B. Sexual Arousal Disorders

1. Female Sexual Arousal Disorder

a. **Medication:** None

b. **Theoretical approaches:** Psychoeducational, Cognitive-Behavioral, Psychodynamic, Systems approaches

c. **Treatment techniques:** Familiarity with a variety of treatment approaches is needed, including knowledge of the underlying principles involved. Strategies involve: 1) encouraging the most comfortable conditions possible in which to experience a natural sexual response, 2) maximizing stimulation, 3) minimizing inhibiting influences. Treatment should be flexible and individually tailored. Techniques can include: general body exploration, genital self-examination, total body pleasuring exercises, genital pleasuring exercises, focused masturbation to orgasm, strengthening the pubococcygeal muscle, stress reduction techniques, relaxation exercises, self-hypnosis, meditation, the body scan (scanning various parts of the body), guided fantasy, erotic literature or films, keeping a sexual diary, play-acting orgasm, as examples.

2. Male Erectile Disorder

a. **Medication:** None

b. **Theoretical approaches:** Behavioral, Cognitive-Behavioral, Psychodynamic, (incl. Interpersonal), Systemic approaches, Psychoeducational

c. **Treatment techniques:** The aims of therapy are: 1) to enhance sexual arousal, 2) to decrease anxiety regarding sexual performance, 3) to address the issues preventing resolution of the erectile dysfunction that limits sexual satisfaction (including cognitive, psychodynamic, relational). Behavioral and cognitive-behavioral treatments have been found to be the most effective (Roth & Fonagy, eds., 1996). Techniques include: accurate information about sexuality that dispel possible myths or inaccurate beliefs, systematic desensitization, relaxation, cognitive restructuring, reframing, modification of maladaptive sexual attitudes, and working through unconscious conflicts. Interpersonal, systemic and psychoeducational techniques are also used at various stages in the treatment.

C. Orgasmic Disorders

1. Female Orgasmic Disorder

a. **Medication:** None

b. **Theoretical approaches:** Psychoeducational, Cognitive-Behavioral, Psychodynamic, Systems approaches

c. **Treatment techniques:** Each client needs to be evaluated on her own characteristics. Treatment techniques described in Female Sexual Arousal Disorder (explained above) are applicable with Female Orgasmic Disorder diagnosis, with attention given to an individually tailored treatment plan.

2. Male Orgasmic Disorder

a. **Medication:** None

b. **Theoretical approaches:** Behavioral

c. **Treatment techniques:** Little study has been done on this disorder, but the following is the standard treatment strategy: eliminate performance anxiety and ensure adequate levels of physical stimulation. The couple is instructed to caress the penis manually (and orally, if acceptable), until erection is attained, then cease stimulation whenever arousal is approaching the point of impending orgasm, reducing the goal-focused anxiety about performance and allowing the man to just enjoy the sexual pleasure. When orgasm is occurring reliably in this manner, the same procedure is used during intravaginal intercourse. If the client presents with life-long and global inhibited orgasm, treatment should begin with the client learning to masturbate.

3. Premature Ejaculation

a. **Medication:** None

b. **Theoretical approaches:** Behavioral (treatment of choice, Roth & Fonagy, eds., 1996)), others used: Cognitive, Psychodynamic, Educational

c. **Treatment techniques:** The goal is to increase the amount of time the man can be aroused without needing to pause. Stop-start or pause procedure (Semans, 1956) is recommended where the penis is manually stimulated until the man is fairly highly aroused. The couple then pauses until the man's arousal subsides, at which time the stimulation is resumed. This series is repeated several times before stimulation is carried through to ejaculation, so the man ultimately experiences much more total time of stimulation than he ever has before, thus learning to have a higher threshold for ejaculation. (This treatment strategy is explained further in Gabbard, 1995, Vol. II.) Also used are behavioral and cognitive-behavioral techniques aimed at reducing sexual anxiety and improving communication concerning the premature ejaculation.

D. Sexual Pain Disorders

1. Dyspareunia

a. **Medication:** None

b. **Theoretical approaches:** Behavioral, Cognitive, Psychodynamic (Interpersonal)

c. **Treatment techniques:** Treatment usually involves the client and his/her partner, seen both together and individually. Assignments include learning to relax and control vaginal dilation and penetration. Challenging unrealistic or unexplored cognitive beliefs and assumptions is important. The man may experience postejaculatory pain syndrome. If so, an organic cause may be determined with appropriate treatment begun. Interpersonal dynamics usually need attention.

2. Vaginismus

a. **Medication:** None

b. **Theoretical approaches:** Psychodynamic, Behavioral

c. **Treatment techniques:** The goal is the extinction of the conditioned vaginal response. Treatment includes: exposure (in fantasy and reality) to the feared situation (the most effective according to Roth & Fonagy 1996) while keeping anxiety at a minimum and providing reasonable reassurance and support. In the psychodynamic approach it is also important to understand the conflicts the woman may be having regarding sexuality, femininity and mature womanhood. Muscle relaxation or desensitization and gradual insertion of objects of increasing size into the vagina under conditions of relaxation and client control are also used in treatment.

E. Paraphilias

(not including Pedophilia or Transvestic Fetishism)

1. Exhibitionism
2. Fetishism
3. Frotteurism
4. Sexual masochism
5. Voyeurism

Similar strategies can be used for all the above paraphilias

a. **Medication:** Testosterone-lowering medications: Cyproterone acetate (CPA), Medroxyprogestrone acetate (MPA), Leuprolide acetate (LPA). The usefulness of antiobsessional medications (e.g.: clomipramine) and other medications is being studied (Gabbard, 1995, Vol. II).

Surgical intervention: castration has been used with a generally low recidivism rate, though it is not condoned for ethical reasons. Stereotactic neurosurgery (making a microscopic lesion at a specific brain site) is considered experimental.

b. **Theoretical approaches:** Psychodynamic, Behavioral, Cognitive-Behavioral, Psychoeducational, Group therapy

c. **Treatment techniques:** Treatment addresses unresolved conflicts responsible for sustaining a paraphilia (including possible developmental issues). Relapse prevention uses strategies used with drug and alcohol addiction. Behaviorists may use forms of aversive therapy, as well as masturbation satiation, and thought blocking. Cognitive-Behavior therapy is used in cognitive restructuring. Specialized group counseling where clients can discuss their sex-related problem (it may be the only place where this is possible for them) can be useful. The group can provide encouragement and support as well as confront denial, minimization and rationalization and provide a forum for teaching relapse prevention strategies. The group strategies may use several models: insight-oriented, cognitive-behavioral, relapse prevention, social skills training. If a client is at high risk of relapse, brief hospitalization may be recommended. Whatever the methods used, documentation of outcome is critical.

2. **Pedophilia**

a. **Medication:** Serotonin reuptake inhibitors, hormonal agents are used. If the behavior is concomitant with a psychotic illness or major depression, drug intervention, hospitalization or both may be necessary.
Psychosurgery: surgical castration and stereotactic neurosurgery are found to be very effective, but are not condoned for ethical reasons.

b. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic, Family Systems, Psychoeducational

c. **Treatment techniques:** Cognitive-behavioral interventions of covert sensitization (identifying the chain of events leading to their pedophiliac acts and pairing these events with potential, negative consequences, olfactory aversion, satiation (training to masturbate to nondeviant sexual fantasies) may help. Also used are: imaginal desensitization, fading, exposure (to erotic adult-adult sexual videotapes or movies), masturbatory conditioning, cognitive restructuring, externalizing cognitive distortions, victim empathy training, prosocial behavior training, psychotherapy focusing on unresolved psychosexual conflicts. Family systems therapy (particularly in cases of incest), focusing on family equilibrium (dysfunctional families may be very resistant to any change brought about by therapy), can be helpful. Sexual addiction treatment, trauma model treatment (treatment to stop the pedophiliac acts and to appreciate the severe consequences of their own molestation), maintenance therapy, surveillance groups, relapse prevention may be part of the approach. Coordinating with other professionals is very important in treatment (Gabbard, 1995, Vol. II).

3. **Transvestic fetishism** - Transvestitism, itself (cross-dressing) does not necessarily constitute a psychiatric disorder.

a. **Medication:** Buspirone, Selective Serotonin Reuptake Inhibitors, Estrogens

b. **Theoretical approaches:** Psychodynamic, Behavioral

c. **Treatment techniques:** "The effectiveness of psychotherapy for either curing transvestitism or alleviating the desire to cross-dress has never been demonstrated" (Gabbard, 1995, Vol. II, p. 1988). Since many of the problems experienced by transvestites are directly related to society's intolerance of transgendered behaviors or gender ambiguity and not of cross-dressing per se (Pomery, 1975), treatment techniques focusing on self-acceptance is a legitimate goal. Decreasing secondary symptoms (e.g.: shame, guilt, depressed mood, suicidality) and addressing issues that might result in adverse social consequences is helpful. Aversion techniques have been found to be powerful, short-term treatments, but may be best used in a multimodal treatment program. Self-regulatory behavioral treatments have been tried. Treatment for the spouses of transvestites may be necessary. They are more likely to seek treatment than the transvestite himself or herself.

4. Gender Identity Disorder

a. **Medication:** Hormonal therapy or surgical reassignment of genitalia may be used.

b. **Theoretical approaches:** Behavioral, Psychoeducational, Psychodynamic (Interpersonal)

c. **Treatment techniques:** Treatment may include individual, group, or family therapy or an eclectic combination of all these therapies. Teaching by example, experience, role-playing, reflecting, nurturing, joining with others in a group, re- evaluation, exploration, validation are all helpful. Assisting clients in looking at options for learning to live with who they are, dealing with "gender guilt" or gender transformation if the client has had a surgical reassignment of genitalia are important techniques.

12. Eating Disorders

"People with eating disorders share many psychological and behavioral characteristics with those who have participated in experimentally and naturally occurring starvation . . . i.e.: preoccupation with food, hoarding, binge eating, cognitive changes, mood lability, apathy, irritability, decreased libido, sleep disturbance . . . Awareness of the symptoms that result from starvation accentuates the importance of nutritional rehabilitation in treatment. Improved nutritional status is necessary for successful psychological intervention" (Gabbard, 1995, p. 2089).

A. Anorexia Nervosa

1. **Medication:** No drug or class of drugs has been found to be an effective "anti-anorectic" agent. Comorbid conditions may require medication, however.

2. **Theoretical approaches:** Behavioral, Cognitive, and Eclectic psychotherapy including dietary management are the most effective (Roth & Fonagy, 1996). Other approaches used with some success are Family (especially with younger clients) and Psychodynamic and Group therapies.

3. **Treatment techniques:** Inpatient or partial hospitalization is often needed. Initial sessions may require meeting more frequently than once a week. Normalization of eating is the first priority. Initial sessions focus on developing the therapeutic rapport with the expectation that the client will be required to gain weight. It is important to establish a weight gain contract. Presenting behavioral and cognitive strategies concurrently rather than sequentially is recommended. Early sessions should include cognitive restructuring. The cognitive model of the relationship of thoughts, feelings, and behavior is explained early in the treatment. Modifying irrational attitudes toward eating, weight and self is essential. Other important treatment issues include: techniques to improve body image, self-esteem, social skills training, assertiveness training. Group treatment with a strong leader can be helpful. In general, treatment should include a combination of medical, nutritional, and psychosocial interventions. Psychodynamic therapy can be very valuable for some clients. Medical monitoring and relapse prevention are essential.

B. Bulimia Nervosa

1. **Medication:** Tricyclic antidepressants, MAOIs, Serotonin reuptake inhibitors (i.e., fluoxetine) are useful in reducing binge-eating and purging.

2. **Theoretical approaches:** Cognitive-Behavioral (including dietary management) and Interpersonal psychotherapy are the most successful (Roth & Fonagy, 1996). Psychodynamic, Group, Psychoeducation, and Family therapies are also used.

3. **Treatment techniques:** Optimal treatment includes nutritional counseling, psychotherapy and pharmacotherapy. Early sessions focus on psychoeducation, the normalization of eating, and establishment of therapeutic rapport. Behavioral and cognitive techniques are then emphasized focusing on eating behavior and weight and body shape. Later sessions include non-food-related issues contributing to bulimic symptoms. Eating and weight issues can be addressed when focusing on self-esteem, depression, interpersonal dysfunction, impulse control, stress management and assertiveness. Final sessions focus on consolidation of information and relapse prevention (Gabbard, 1995, Vol. II). Cognitive-Behavioral treatment focuses on modifying behaviors and thinking patterns for more adaptive coping strategies and to eliminate bulimic symptoms. Some clients find psychodynamic therapy an important asset to their treatment. Interpersonal techniques based on therapy for depression with no attention paid to the eating disorder has shown some positive results.

C. Atypical-Eating Disorders

Binge Eating Disorder (the most prevalent of the atypical eating disorders)

1. **Medication:** Serotonin reuptake inhibitors (i.e., fluoxetine) are useful.

2. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic (Interpersonal) may be helpful

3. **Treatment techniques:** Cognitive-behavioral techniques of restructuring, disputing irrational beliefs, cognitive homework, changing distorted thinking can all be helpful (as they are in bulimia nervosa). Interpersonal techniques based on therapy for depression with no attention paid to the eating disorder has been shown to be helpful, as in bulimia nervosa.

13. Sleep Disorders

General treatment principles:
- a good therapeutic alliance
- establish realistic goals and expectations

A. Dyssomnias

1. Primary Insomnia

a. **Medication:** Benzodiazepines, Antidepressants

b. **Theoretical approaches:** Behavioral, Cognitive

   c. **Treatment techniques:** Stimulus control and sleep restriction are the most effective single treatment modality. Relaxation methods have also been found to be helpful. Cognitive therapy is used in alleviating emotional distress and in teaching skills for coping with residual sleep disturbances.

2. **Primary Hypersomnia**

   a. **Medication:** Stimulants are directed symptomatically at daytime alertness

   b. **Theoretical approaches:** No specific psychotherapeutic approach.

   c. **Treatment techniques:** Daytime naps may be recommended, but not to disrupt nocturnal sleep. Long naps are generally not refreshing in these clients. Encouraging a regular sleep-wake schedule in clients with this diagnosis is helpful. Clients should have a thorough diagnostic work-up to exclude other disorders such as narcolepsy, breathing-related sleep disorder, and periodic limb movements during sleep.

3. **Narcolepsy**

   a. **Medication:** Stimulants

   b. **Theoretical approaches:** Group therapy

   c. **Treatment techniques:** Three to four short (15-minute) naps per day are useful in conjunction with stimulant medications. These should be scheduled at strategic times (e.g., before driving.) Alertness can improve and the need for stimulant medications can decrease. Very regular sleep-wake schedules are very important. Narcolepsy is a lifelong condition and can cause significant problems. Supportive group therapy can help the client adjust her/his lifestyle to the chronic nature of this disorder. It can also be helpful in learning to cope with the consequences of the sleep problem.

4. **Breathing-Related Sleep Disorder**

   a. **Medication:** No medication is recommended for the apnea per se, but may be prescribed for other associated symptoms.

   b. **Theoretical approaches:** Behavioral

   c. **Treatment techniques:** General avoidance measures, sleep position training, and weight loss for obese clients can be helpful. Avoidance of sedative-hypnotics and alcohol 4-6 hours before bedtime is recommended. Assisted ventilation is used.

5. **Circadian Rhythm Sleep Disorder**

   a. **Medication:** Short-acting benzodiazepine hypnotics are sometimes used.

   b. **Theoretical approaches:** Behavioral

c. **Treatment techniques:** Chronotherapy is the only behavioral treatment that has received much research attention. It may be helpful for some clients. A more effective method may involve a strict schedule of an early and regular rising time. Jet lag and shift work sleep rhythm problems may be able to be managed by preventive, environmental and rescheduling measures. It is also important to keep sleep episodes and meals scheduled at regular times. Rotating shifts that move from days to evenings to nights are easier to adapt to than shifts that rotate in a counterclockwise direction. Circadian adaptation may be helped by rapid (every 2- 3 days) or long (about 3 weeks) shift rotations. Appropriately timed, bright white light can be helpful.

B. Parasomnias

1. Nightmare Disorder

a. **Medication:** Not well established in controlled clinical trials. Medications found to have some effect with some clients: benzodiazepines, cyclic antidepressants. Nightmares associated with PTSD may improve with potent REM-suppressing medications (e.g., MAOI's)

b. **Theoretical approaches:** Behavioral

c. **Treatment techniques:** Anxiety reduction i.e., relaxation, exposure-based interventions, i.e., systematic desensitization, rehearsal.

2. Sleep Terror Disorder

a. **Medication:** Benzodiazepines

b. **Theoretical approaches:** Hypnosis, Psychodynamic

c. **Treatment techniques:** Parents of children with sleep terror disorder should be reassured of the normal development of these episodes. The events should be let to run their course, with intervention only to keep the person safe and to prevent sleep deprivation. It is suggested not to arouse the person (child or adult), but to be reassuring, give verbal instructions and physically help them to return to bed. If life stressors or psychiatric symptoms are being experienced by the client, stress management and problem-solving can help. Psychodynamic therapy is sometimes used to gain insight into the stress and help the person change her/his coping strategies. Hypnosis has been used for improved self-control.

3. Sleepwalking Disorder

a. **Medication:** Benzodiazepines

b. **Theoretical approaches:** Hypnosis, Psychodynamic

c. **Treatment techniques:** Since sleep terror and sleepwalking have common features, often occur together and may be part of the same phenomenon, the treatment techniques are similar. One difference is that sleepwalking can be life-threatening, thus it is important to attend to the safety of the person, immediately. The person may need to sleep on the ground floor. Bedroom windows and doors may need to be locked. Removing all potentially dangerous objects, including weapons may need to be done. Rearranging potentially harmful furniture may be important. If sleepwalking is drug induced, the schedule of taking the medication should be changed.

4. **Sleep Disorders Related to Another Mental Disorder**

   a. **Medication:** Medication should be directed to the underlying disorder (i.e., mood disorders)

   b. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic

   c. **Treatment techniques:** Techniques used are: elimination of daytime napping, strict enforcement of a regular rising time, reduction of caffeine intake. The combination of pharmacotherapy, behavioral therapy and psychodynamic therapy has been used effectively.

14. Impulse-Control Disorders Not Elsewhere Classified

A. Intermittent Explosive Disorder

1. **Medication:** Medication depends upon the particular impulse-control disorder and consideration of which clients will comply with the pharmacological treatment given. Anticonvulsant drugs may be used, lithium has been effective for violent prisoners who showed impulsive aggression. Beta-blockers have been found to be useful in treatment of temper or in clients with chronic brain syndromes, including mental retardation. One study found the use of buspirone helpful for therapy of impulsive violence in mentally retarded clients (Gabbard, 1995, Vol. II).

2. **Theoretical approaches:** Behavioral, Cognitive-Behavioral, Psychodynamic.

3. **Treatment techniques:** Very little research has been done regarding the treatment of this disorder beyond the use of pharmacological interventions. Many persons with this disorder are often incarcerated, then hospitalized or treated as psychiatric outpatients. Behavioral and cognitive-behavioral programs can help clients learn new, more socially accepted behavior as well as handling stress that may become a crisis. If the behavior is a result of difficulty handling emotional material, psychodynamic therapy can help the client become more aware of anger buildup. These clients may also turn their anger inward and become suicide risks. Since drugs and/or alcohol are often a major part of violence, it may be necessary to treat the client for an addiction.

B. Kleptomania

1. **Medication:** Antidepressants have been useful.

2. **Theoretical approaches:** Behavioral, Psychodynamic, Supportive therapy, Family therapy

3. **Treatment techniques:** Aversive behavior therapy and desensitization have been used with these clients. Psychodynamic and supportive therapy along with antidepressants have been helpful. Stressors (particularly losses and anniversaries) may increase the risk of stealing. Clients may be encouraged not to shop alone. Family therapy may be needed.

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C. Pyromania

1. **Medication:** Serotonin uptake inhibitors, Anticonvulsants, Antidepressants
2. **Theoretical approaches:** Psychodynamic, Behavioral, Cognitive-Behavioral, Family
3. **Treatment techniques:** This condition is the most dangerous of the Disorders of Impulse Control. Close follow-up is extremely important. Treatment may be long-term and chronic. Psychodynamic therapy focusing on exploration of a possible traumatic and abusive childhood, cognitive awareness of the consequences of fire setting, awareness of the excitement and arousal preceding the fire setting are important in the treatment. Confrontational techniques may be needed. Substance abuse treatment may be appropriate. Systematic empirical drug trials along with psychotherapy focused on underlying conflicts &/or behavior therapy are used together.

D. Pathological Gambling

1. **Medication:** Clomipramine and a combination of fluoxetine and clomipramine
2. **Theoretical approaches:** Psychodynamic, Behavioral, Cognitive-Behavioral, Rational-Emotive, Reality therapy, Gamblers Anonymous
3. **Treatment techniques:** Psychodynamic therapy is used to understand why the client gambles and to deal with the unbearable feelings that lead to the gambling. Dealing with the underlying anxiety or depression, the excess of time, budget counseling and other reality factors are important. Therapy including the partner can be helpful. Multiple addictions along with comorbid psychopathology and/or personality disturbances may be a part of the presentation. Stress-related physical disorders may need attention. Individual, and group counseling where new behaviors can be learned as well as receiving feedback are recommended.

E. Trichotillomania

1. **Medication:** Antidepressants, particularly Clomipramine
2. **Theoretical approaches:** Behavioral, Psychodynamic, Supportive therapy
3. **Treatment techniques:** Behavioral techniques of habit reversal, i.e., fist-clenching as a substitute for hair pulling, behavior awareness of the hair pulling, identification of the antecedents to the hair pulling, progressive relaxation are used. Behavioral rewards may be given. Behavior therapy in combination with pharmacotherapy may be helpful. Psychodynamic and/or supportive therapy may be necessary in addition to addressing any underlying mood disturbance.

15. Adjustment Disorders

A. Medication: Antidepressants - be aware of any more serious mental disorder.

B. Theoretical Approaches: Cognitive-Behavioral, Psychodynamic (Interpersonal), Supportive therapy, Psychoeducational, Family therapy, Group therapy

C. **Treatment Techniques:** Analyze the stressors first, to see if they can be changed in any way. Clarify and interpret the stressors for the client. Medical crisis counseling may be necessary. Crisis intervention helps the client put words to the affects and conflicts to reduce the pressure of the stressors and enhance coping. Help the client identify means to reduce the stressors, using and expanding their coping skills. Encourage the client to gain perspective on the problems, to seek out relationships or establish new ones, to attend support groups, self-help groups. Assist the client in management of the stressors. Psychoeducational and cognitive-behavioral therapy can help the client understand the stressors and change inappropriate cognitions.

Axis II

16. Personality Disorders

Although as stated elsewhere in this manual (Diagnosis chapter), personality disorders are long-standing, deeply ingrained, ego-syntonic, and potentially life-long. Gabbard (1995, Vol. II) also notes that these disorders "are not uniformly stable and unchanging". . . . that they "emerge at different ages". . . . and that "the prevalence rates of major disorders, such as borderline, narcissistic, and antisocial personality, vary with age" (p. 2246). He further suggests that "such observations reflect unsuspected variability in the course of these disorders and raises the hope that they can be influenced preventively or correctively through treatment" (p. 2246).

Persons with personality disorders are very challenging clients. Their symptoms often do not appear as serious as some of the clinical disorders, and they may need long-term, extensive treatment because their disorders are so deeply ingrained. Psychodynamic therapy has, in the past, been the treatment of choice with these clients. However, with the recognition of the need for, and value of, more time-limited therapies, the multimodal, and sequential usage of the variety of modalities available should be considered in treatment of clients with personality disorders. In particular, cognitive-behavioral and pharmacotherapies (both focusing on specific problems) may be used during certain phases, especially early in therapy, as part of a longer-term treatment plan. Even though clients with personality disorders may come for treatment and ask for help, they, typically, are very resistant to change. They often have few inner resources and few environmental supports, therefore change can be very frightening. These clients may terminate treatment prematurely.

The overall treatment plan has two levels:

- The therapist must first deal with the presenting (concrete) problem, in order for the client to feel relief and to demonstrate that the therapist can help. The presenting problem may not be a part of the underlying personality disorder. This phase should be active, structured, concrete and behavioral or cognitive-behavioral. Pharmacotherapy may also be used.

- The second level of treatment (after the therapeutic alliance has been established, and the client has made a commitment to work with the therapist for a longer period of time) shifts to a more psychodynamic approach to deal with the underlying personality disorder. Cognitive-behavioral techniques and pharmacotherapy may, at times, be helpful here, also.

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A. Cluster A: Odd, eccentric group

(the most resistant to treatment)

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder

1. Paranoid Personality Disorder

a. **Medication:** Medication is often not effective, because of the paranoia. At specific times, limited use of minor tranquilizers for anxiety or a tricyclic or antiserotonergic antidepressants or MAOIs for phobic anxieties or depression might be helpful (Gabbard, 1995, Vol. II).

b. **Theoretical approaches:** Behavioral (for secondary symptoms such as phobic anxiety), Psychodynamic

c. **Treatment techniques:** Care must be taken for the therapist not to become "the enemy". Establishment of a meaningful therapeutic alliance is critical. Respect for the client's autonomy, consistent empathy and tolerance for, and nonjudgemental acceptance of the client's feelings are essential. Attempting to convert the paranoid stance into the underlying depression is needed, then working with the depression. Techniques include empathically eliciting the details of the client's projective system and inner conflicts and self-dislike. Helping the client look at the self-defeating cycles he/she engages in to see how his/her behavior contributes to other people's responses. "Counterprojection" of acknowledging and accepting the client's feelings and perceptions without reinforcing them is also used. Systematic exploration of the client's fears and convictions to develop other explanations and strategies for dealing with people and situations can be helpful. Techniques of confrontation, challenge or reality testing are not helpful with these clients.

2. Schizoid Personality Disorder

a. **Medication:** None recommended

b. **Theoretical approaches:** Psychodynamic, Supportive, Cognitive-Behavioral

c. **Treatment techniques:** These clients may come to therapy only at the urging of others and may drop out of treatment quickly. Psychodynamic therapy is used with clients who are avoidant, rather than indifferent, to human closeness and have a good degree of psychological mindedness (open to self-awareness and working with psychological material). Use of dream analysis, exploring the client's fantasies, and identifying the client's use of splitting and projective identification as defenses have been helpful. Supportive therapy can be very important and may include: sympathetic listening, education about the world, giving advice, problem-solving, and slowly, patiently establishing a relationship with the client. Helping the client be less anxious in social situations by exploring his/her negative assumptions is useful. A "dysfunctional thought record" where typical negative thoughts and assumptions are listed can be used. Giving assignments i.e., around developing a social network and cognitive restructuring i.e., of negative and self-defeating assumptions is helpful. It may be necessary to help these clients find the right job where they can be successful, which is usually one with minimal contact with others. Individual and group therapy are used. Family therapy can be helpful, especially with young clients.

3. Schizotypal Personality Disorder

a. **Medication:** Antianxieties (small doses), Neuroleptics (low doses) with clients with illusions, ideas of reference, and proneness to psychotic ideation (Gabbard, 1995)

b. **Theoretical approaches:** Psychodynamic, Supportive, Cognitive-Behavioral, Reality Therapy

c. **Treatment techniques:** Medication may be used symptomatically. However, some clients do not respond well. Many treatment interventions used with Schizoid Personality disordered clients are also useful with clients with Schizotypal Personality Disorder. Additionally, helping these clients with a better understanding of reality and how their behaviors are not working for them may also be helpful. Suggesting different ways to interact with the world may be needed. Individual, group and family therapy are used with these clients.

B. Cluster B: Dramatic, emotional, erratic, egocentric group

Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder

4. Antisocial Personality Disorder

a. **Medication:** Medication for specific symptoms and behaviors may be prescribed if compliance supervision is maintained. Selection of medication may be predicated on the mode of the client's violence. Specific medications have been shown to inhibit particular modes of violence.

b. **Theoretical approaches:** Clients with this disorder and a concomitant psychopathic disorder respond very poorly to most theoretical approaches to treatment. Nonpsychotic adults with antisocial personality disorder may respond to the following approaches to some degree: Family, Cognitive-Behavioral, Psycho-dynamic. Children with conduct disorder may respond more positively than adults to family therapy.

c. **Treatment techniques:** An assessment must first be made as to whether the treatment setting is secure enough, for both clinician and client, in order to treat a client with this disorder. The therapist may hold both reality-based and countertransference fears of working with these clients. Clients with this disorder who survive into their 40's tend to become less impulsive and less antisocial. If substance abuse is part of the presenting problem, treatment for that disorder is appropriate. These clients often have episodes of depression and suicide risk needs to be assessed. Treatment for depression may be necessary. Clients with antisocial personality disorder have been found to generally respond better to cognitive-behavior therapy treatment if they are motivated to change and are in a milieu or residential setting. Gabbard (1995, Vol. II) quotes an anonymous Australian psychiatrist as saying, when describing treatment for these clients: "Basically it is symptomatic relief, clear guidelines about expected behavior, treatment of any major psychotic illness, realistically accepting them as they are and trying extremely hard not to be too frightened of them" (p. 2290).

5. Borderline Personality Disorder

a. **Medication:** Collaboration with the client regarding assessment for a medication trial is helpful. Medication can be targeted for: cognition (use of low doses of neuroleptics), affect (antidepressants may be warranted), impulse control (medication should be chosen on the basis of their side-effect and potential lethality from overdose), anxiety (somatic - MAOIs or catecholaminergic medications; psychic anxiety - benzodiazepines [but can lead to dependency on the medication]) (Gabbard, 1995, Vol. II).

b. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic, Supportive

c. **Treatment techniques:** Individual psychotherapy is the norm, while family and group therapy can be very helpful. Being aware of any suicidality is important with these clients. Development of a working relationship with clients with this disorder is a necessity. Cognitive-behavioral therapy first focuses on symptoms of depression and any substance use, then expands to helping the client with his/her sensitivity to rejection, self-destructive and aggressive behavior, depersonalization, and black and white thinking. Techniques include confronting irrational beliefs, modeling, cognitive restructuring. However, usual strategies of cognitive-behavioral therapy need modification including greater flexibility in the therapy and greater attention to the creation and maintenance of the therapeutic relationship. Psychodynamic therapy focusing on increasing insight and providing a corrective emotional experience is often very helpful. Supportive therapy with the focus on reality problems of daily life is often used. Follow-up with clients with this disorder has found that short-term therapy has not been as successful as at least one to two years of treatment and some clients are in treatment for longer periods of time. Time-limited (6-12 months) therapy focuses on specific situational or interactional problems, but because of the lack of transference gratification many borderline clients drop out (Gabbard, 1995, Vol. II). Frances and Ross (1996) note that "Time is on our side in treating Borderline Personality Disorder. A number of studies indicate that the long-term prognosis is surprisingly good because patients seem to mellow out with age" (p. 298).

6. Histrionic Personality Disorder

a. **Medication:** None recommended

b. **Theoretical approaches:** Psychodynamic, Behavioral-Cognitive, Psychoanalysis, Marital, Group

c. **Treatment techniques:** Horowitz (in Gabbard, 1995, Vol. II) describes four phases of formulation and treatment for clients with this disorder. She encourages an integrative approach using psychodynamic and cognitive-behavioral formulations and techniques. She suggests using "psychodynamic approaches for how to establish a therapeutic alliance, understand and handle various motivational levels of transference, and counteract resistances to change. Cognitive-behavioral means can be employed for identifying irrational cognitions, disruptions of clear conscious representation and expression, and techniques that reinforce the repetition of more adaptive actions" (p. 2314). The four phases are identified as: 1) Clarifying symptomatic phenomena and establishing a therapeutic alliance, 2) Identifying and dealing with shifts in state of mind, 3) Identifying and counteracting defensive control processes, 4) Identifying and helping the (client) to modify irrational beliefs and contradictions in schemas of self.

7. Narcissistic Personality Disorder

a. **Medication:** None for the personality disorder, itself. Pharmacotherapy is indicated for treatment of comorbid Axis I conditions, i.e., affective or anxiety disorders.

b. **Theoretical approaches:** Supportive, Psychodynamic, Cognitive-Behavioral

c. **Treatment techniques:** The goal of therapy needs to be established at the beginning. Is the goal to give support or is change the goal? Brief therapy using psychodynamic and cognitive-behavioral techniques may include: increasing insight, modifying of destructive behavioral patterns, pointing out the client's own role in generating and perpetuating his/her life problems and defining the client's task as not acting impulsively and focusing on trying to see the other person's point of view. Longer term therapy includes a flexible therapeutic attitude toward the client, and balancing empathy and anxiety in the therapy to push the client toward greater self-awareness. Empathic acceptance is greater in the early part of treatment, while interpretive challenging is used more later. It is important to address the client's subtle expressions of devaluation of the therapist in order that the therapy will not be undermined. Addressing the harshness of the client's conscience is important in the therapy. Both couples therapy and group therapy can be helpful, but individual therapy should be taking place concomitantly.

C. Cluster C: Anxious, fearful, indirect group

Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Personality Disorder NOS

8. Avoidant Personality Disorder

a. **Medication:** MAOIs and benzodiazepines are used for clients with generalized social phobia and may be helpful with avoidant personality disorder. No other medication is recommended as a primary form of treatment.

b. **Theoretical approaches:** Cognitive-Behavioral, Rational-Emotive, Psychodynamic including Interpersonal

c. **Treatment techniques:** These clients may be very apprehensive when entering therapy, necessitating careful, deliberate beginning treatment. Establishment of a therapeutic alliance is essential. Anxiety management early in therapy is important. The following cognitive-behavioral techniques are used: social skills training, in conjunction with exposure techniques, (either graduated or flooding) which exposes the client to experiences they have been avoiding, systematic desensitization, cognitive restructuring and other cognitive techniques targeting the client's false assumptions about the effects of failure. Psychodynamic and/or interpersonal therapy, either as a primary treatment or as an adjunct to a cognitive-behavioral approach is helpful for many clients. The combination of psychodynamic and cognitive-behavioral therapy may be most useful. Exploring the psychodynamic meaning of their anxiety and the source of their fears (often shame and embarrassment) is important, since these clients often shun personal interactions to avoid self exposure and the expected criticism. Behavioral exercises help desensitize the client and introduces further material for the psychodynamic work. Interpersonal therapy provides these clients with a healing interpersonal experience in the therapeutic relationship. If family treatment is considered, the family should be educated about the importance of behavior changes in the client. Group therapy is generally not helpful.

9. Dependent Personality Disorder

a. **Medication:** Medication may effect some clients with a concurrent Axis I disorder (i.e., depression), but there is little evidence of benefit for the dependent personality disorder, itself.

b. **Theoretical approaches:** Psychodynamic, Cognitive-Behavioral

c. **Treatment techniques:** Developing a trusting relationship and allowing the client to transfer dependent wishes onto the therapist is important when beginning work with these clients. The dependent transference toward the clinician is dealt with in a way to promote emotional growth. Also to be addressed is the use of therapist expectations and support for the client to develop self-expression, assertiveness, decision making and independence (Beck, et al, 1990). The therapist should help the client conceptualize his/her own goals and, if healthy, the therapist should discuss and support them. It is important to discuss the consequences of each client goal and for the therapist to give support to help the client tolerate the anxiety of making choices. The client is then encouraged to commit to progressively more complicated actions related to the choices. In cognitive-behavioral therapy, the client's dependent behavior is accepted at first, but self-reflection, agenda setting and treatment goals are then encouraged. Techniques include: challenging dichotomous thinking, graded in-vivo exposure to anxiety-provoking situations, monitoring of client's automatic thoughts (particularly of inadequacy), challenging the client to select healthier responses, relaxation training, assertiveness training. Group psychotherapy can be helpful in treatment of these clients.

10. Obsessive-Compulsive Personality Disorder

a. **Medication:** There are no medications specifically for this disorder. Nonspecific anxiolytics may be used, but attention must be paid to the possibility of medication dependency. Antidepressants may be useful with clients with significant depressive symptoms.

b. **Theoretical approaches:** Psychodynamic, Cognitive

c. **Treatment techniques:** Individual psychodynamic therapy or psychoanalysis is the treatment of choice, although formal outcome studies have not been carried out. The client's use of defenses (i.e., intellectualization, isolation of affect, undoing, reaction formation, displacement, and regression) must be supportively pointed out and questioned so the client can learn how he/she tries to control the anxiety he/she experiences. Education of the client is important so she/he will understand that the controlling, rigid style prevents satisfying relationships and damages work performance. Addressing the resulting anxiety and projection onto the therapist of expected punishment and retaliation is necessary. Paying attention to the reality distortions the client experiences, allows for understanding of his/her feelings of guilt regarding his/her impulses and his/her need to be punished. As the client becomes more aware that his/her hostile or erotic thoughts and impulses are not the same as actions, and do not necessitate moral censure, he/she will become less anxious, experience less harsh and self-judgmental attitudes, and his/her defenses will become less rigid and exacting. The client's self-expectations will be modified. Intensive group treatment may be useful with these clients. Short-term therapy may be used with clients with obsessive-compulsive personality disorder when they are in the midst of a crisis. Focused goals in helping the client accommodate to change may be used. Gabbard (1995, Vol. II) reported one 16-session therapy study found moderate changes in personality, including a decrease in negative and ambivalent self-references, and an increase in positive self-references. Also some decrease in procrastination and narcissism was found. The therapist may experience countertransference problems which need to be addressed in supervision and/or personal therapy so as not to impede the therapeutic work with these clients.

Major sources for this chapter: Frances & Ross, 1996; Gabbard, 1995; Roth & Fonagy, 1996; Seligman, 1990.

CHAPTER 6

Counselling Theories

PSYCHODYNAMIC PSYCHOTHERAPIES

These theorists believe that the personality is the result of interactions of opposing (instinctual) forces which create conflicts within a person. The task of psychotherapy is to understand these forces, resolve the conflicts and bring the forces into more harmoneous functioning.

1. Psychoanalysis - Sigmund Freud

Psychoanalysis is both a method of therapy and a theory of personality. To understand the goals and techniques of Freud's psychotherapy, one must understand the personality theory behind it (See Personality Theories). Freud developed his hypothesis about the role of the unconscious processes in hysteria and other mental disorders and the benefits of "free association" and "catharsis" while treating women with these disorders (ex: the case of Anna O.).

Psychoanalysts understand maladaptive behavior as a reflection of unresolved, unconscious conflicts that occurred in childhood. The goal of treatment is to change the maladaptive behavior (pathological symptoms) by bringing into consciousness unresolved, unconscious material and integrating it into the total personality structure.

Freud believed the therapist should be a "blank screen" against which the client's unconscious associations (and therefore conflicts) could appear more clearly.

The therapist then uses the following techniques to address the client's material.

- clarification - restating client's statements and feelings
- confrontation - helping clients see behavior in a new way
- interpretation - explicitly connecting present behavior to unconscious processes
- working through - clients assimilating new insights into their personality

Catharsis is important in psychoanalysis. This phenomenon is the emotional release resulting from recall of previously unconscious material. It allows "insight" to happen where the client becomes aware of unconscious conflicts underlying her/his dysfunctional behavior.

2. Neo-Freudians

Neo-Freudians, generally, reject Freud's view of personality as being determined primarily by instinctual forces and instead emphasize the role of social and cultural factors. Many basic techniques of classical psychoanalysis are used to understand the client's social environment.

A. **Karen Horney** was trained in the orthodox psychoanalytic tradition, but early in her career she challenged Freud's ideas on feminine psychology, on the nature of the neurotic process, on the concept of the death instinct, and particularly on the role of cultural factors in neurosis. She formulated a holistic notion of the personality as an individual unit functioning within a social framework and continually interacting with its environment. At the center of her theory was the concept of the self. She believed that an actual self, a real self, and an idealized self were the main facets of the personality. The actual self is the sum total of the individual's experience. The real self is a more central force or principle, unique within each individual and equivalent to a sense of healthy integration or harmonious wholeness. The idealized self is a manifestation of neurosis and serves as a means of avoiding psychic conflict by adopting an attitude of superiority or self-sufficiency or by demanding special consideration. The idealized self is a form of glorified self-image that can progressively encompass more aspects of the personality.

   Horney rejected symptom relief or social adjustment as adequate therapeutic goals for therapy. Instead, she emphasized self-realization and self-actualization, dealing with the here and now in contrast to the results of past experience. She felt that the emotional involvement between therapist and patient was an important aspect of the therapeutic process and rejected the stereotype of the analyst as a detached, unfeeling, unresponding mirror.

B. **Harry Stack Sullivan's Interpersonal Psychotherapy** focuses on anxiety and the interpersonal context in which it occurs. Therapy is viewed as a succession of interviews where the therapist is both an active participant in the exploratory process and the observer of trends in the client that the client's defensive patterns prevent him/her from noticing. Personality is viewed as a collection of processes that occur as an outgrowth of interpersonal experiences and not the unfolding of intrapsychic forces.

   Sullivan agreed with Freud that personality development involved predetermined sequences of stages. He described each stage as being characterized by different interpersonal factors rather than instinctual ones as Freud did. Sullivan also recognized the role of cognitive experience in personality development. He believed that a person achieved mental health to the extent that she/he became aware of her/his interpersonal relationships.

   The primary goal of Interpersonal Psychotherapy is to identify and correct the client's distortions where the client responds to a person as though she/he were a significant person from their past. This is necessary in order for the client to have more realistic and mutually satisfying relationships.

C. **C. G. Jung's Analytical Psychotherapy** "is an attempt to create a dynamic interplay between the conscious and the unconscious through the use of symbolism. Analytical Psychology regards the psyche as a self-regulating system whose functioning is (purposeful) in that it confronts the (person) with an internally imposed direction toward a life of fuller awareness" (Whitmont and Kaufmann, 1973, p. 85). A dialogue is developed with dreams, fantasies and other unconscious material, between the conscious state of the person and his/her personal, as well as the collective, unconscious. Therapy is not seen as a fixed structure, but as a process of self-knowledge, a reconstruction of the personality or even as an education.

The most important principal in Jungian psychotherapy is that the basis of any analysis is experiencing, not merely intellectual understanding. Therapy involves an active interchange between the analyst and the client with the main emphasis on the conscious assimilation of the immediate experience. Interpretation is the main work of the analytic process. Analysis attempts to make conscious, as much as possible, what has been unconscious, making a behavioral change possible.

3. Ego-psychology

Anna Freud
Heinz Hartmann
David Rapaport
Erik Erikson
Otto Kernberg

Ego-psychologists stress the development of a variety of ego functions.

A. Ego-Defensive Functions

Ego-defensive functions develop through the resolution of conflicts. These bear some similarity to Freud's "ego". Anna Freud delineated several ego defenses (regression, repression, reaction formation, isolation, undoing, projection, introjection, turning against the self, displacement, identification with the aggressor) which function as positive coping mechanisms or neurotic defenses depending on the success of the conflict resolution. She also posits a developmental sequence of emergence of the defenses.

B. Ego-Autonomous Functions

Hartmann and his followers propose a more "conflict-free" ego, which includes adaptive and non-conflictual functions such as: perception, intuition, comprehension, thinking, language and learning. Hartmann's theory focuses on the positive adaptations of the ego created outside of instinctual conflicts and the balancing of the internal and external forces required for the optimal functioning of the individual.

Treatment goals and techniques are similar to classical psychoanalysis, but tend to emphasize current problems as opposed to past experiences. The focus is on neurotic as well as non-neurotic parts of a client's personality. There is more emphasis on providing clients opportunities for "re-parenting" rather than emphasizing the transference.

4. Self Psychology

Self Psychology is derived from the work of Hartmann, Erikson and Lichtenstein. The major contemporary theorist is Heinz Kohut, who views the self as a separate narcissistic structure independent of id, ego and superego. The self is seen as either separate from the ego or as a supraordinate integration of the id, ego, and superego. Narcissism is believed to undergo its own separate line of development through several phases toward a mature, cohesive self-organization.

BEHAVIOR THERAPY

(Wolpe, Skinner, Lazarus)

Both Classical Conditioning (Joseph Wolpe) and Operant Conditioning (B. F. Skinner) emphasize current behaviors, reject the premise that maladaptive behavior is symptomatic of underlying psychopathology, and regard maladaptive behavior, itself, as the psychological disorder. In the classical conditioning approach, certain respondent behaviors such as knee jerks and salivation are believed to be elicited from a passive organism. In operant conditioning, operant behavior is seen as action that operates on the environment to produce consequences. The primary goal of treatment is the elimination of maladaptive behavior. The current trend in Behavioral Therapy is toward developing procedures that give control to clients and thus increase their range of freedom. Behavior modification works toward increasing a person's skills in order for that person to have more options for responding. This process is seen to increase rather that to restrict individual freedom. Arnold Lazarus has been a major force in behavior therapy. He worked with Wolpe, but split with him when he thought Wolpe was too rigid and narrow in his outlook.

COGNITIVE-BEHAVIORAL THERAPY

All of the Cognitive-Behavioral therapies emphasize the collaborative relationship between therapist and clients. They believe that psychological problems are mostly a function of disturbances in cognitive processing. They focus on changing cognitions in order to change affect and behavior. These theories are generally time-limited and treatment is psychoeducational and focused on specific and structured target problems.

1. Rational Emotive Therapy (RET) (Albert Ellis)

Albert Ellis' Rational Emotive Therapy (RET) is now known as Rational Emotive Behavior Therapy (REBT). This theory is based on the assumption that people contribute to their own psychological problems and specific symptoms by the way they interpret events and situations in their life. Ellis' approach is known as the A-B-C theory of personality: A is the actual event; B is the person's belief system and C is the consequence. He sees emotional problems as the result of the person's beliefs, which must be challenged. He uses the method of logical and rational thought to apply to irrational beliefs. Cognitive therapy is used to change dysfunctional emotions and behaviors by modifying what is seen as inaccurate and dysfunctional thinking. The techniques used are designed to identify and test the person's misconceptions and faulty assumptions. Ellis believes that a reorganization of one's self-statements results in the reorganization of one's behavior.

2. Cognitive Therapy (Aaron Beck)

Cognitive Therapy focuses on the understanding of emotional problems through the cognitive content of a person's reaction to that problem. The goal of therapy is to change dysfunctional emotions and behaviors by modifying inaccurate and dysfunctional thinking. Clients learn to identify these distorted and dysfunctional cognitions through a process of evaluation. They learn to discriminate between their own thoughts and reality; to be aware of and monitor their thoughts and assumptions, particularly their negative, automatic thoughts. Beck does not believe in the concept of irrational beliefs. He sees beliefs as problematic, but not irrational. Some techniques used are: assertiveness training, behavioral rehearsal, graded task assignments, relaxation methods, shame-attack exercises, thought stopping, cognitive restructuring. Cognitive therapy is particularly

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used in depression, but is applicable with other diagnoses as well. In recent development of the theory, cognitive therapists are focusing on the client's subjective framework and interpretation as being more important than the objective of distorted beliefs. This "constructivist's" perspective stresses the client's reality rather than the accuracy or rationality of the thought.

3. Social Learning Theory (Albert Bandura)

Bandura combines learning by classical and operant conditioning of the behaviorists, with learning by observation and imitation, using modeling as the technique for learning. An individual or group models or acts as a stimulus for similar thoughts, attitudes, and behaviors of the observers. In observation and modeling, a client can learn to perform particular acts or think in particular ways without trial and error learning. He believes that modeling is paramount in the development and modification of much of human behavior.

Social Learning theory sees three major effects of modeling:

1. learning of new responses or skills and the performance of them
2. inhibition of fear responses
3. facilitation of responses already learned

Types of models used:

1. live models
2. symbolic models (films, videotapes, etc.)
3. multiple models (successful peers, co-leaders, etc.)

HUMANISTIC THERAPIES

1. Gestalt Therapy (Fritz Perls)

Gestalt Therapy, the system of psychotherapy developed by Fritz Perls is an existentially based system that is noninterpretive, nonhistoric and follows the principle that the whole is greater than the sum of its parts. The primary focus is the here-and-now. The process of the therapist-client relationship is of central importance since it is the quality of the relationship that determines what happens in the therapy. The process of interactions, not the content, is the major focus. Gestalt therapy focuses on the immediate present awareness of one's experience. The concepts of transference and countertransference are thought not to apply and cognitive explanations or interpretations of "causes" or "purposes" of behavior are rejected.

2. Person-Centered Therapy (Carl Rogers)

Person-Centered Therapy developed by Carl Rogers posits that human growth is a process of continual development and change. The central hypothesis is that the growthful potential of any individual will tend to be released in a relationship where the helping person is experiencing and communicating realness, caring and deeply sensitive nonjudgemental understanding. Rogers views a person's underlying nature as self-actualizing. The inherent tendency of the organism is to develop all its capacities in ways which serve to maintain and enhance the organism. Growthful change will take place if the therapist exhibits attitudes of congruence, positive regard and empathic understanding toward the client.

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REALITY THERAPY (WILLIAM GLASSER)

William Glasser's Reality therapy involves a series of theoretical principles that can be applied to persons with behavioral or emotional problems or anyone seeking to gain a success identity. The focus is on the present and on behavior. The therapist guides the person to see him/herself accurately, to face reality, and to fulfill his/her own needs without harming him/herself or others. The major principle is personal responsibility for one's own behavior which is equated with mental health. Reality therapy is used successfully with adolescents, individually and in groups as well as with adults who are substance abusers. It began in, and continues to be used in, institutional settings, as well as outside these settings.

TRANSACTIONAL ANALYSIS (TA) (ERIC BERNE)

Eric Berne's theory of Transactional Analysis includes the presence of three ego states that are active, dynamic and observable. They are referred to as the Parent, the Child, and the Adult. Each of these states is theorized to exist and operate in any individual. Persons are motivated by a need for strokes (recognition) and will design a life script based upon early childhood beliefs about oneself and others. These existential beliefs are reinforced by a person engaging in repetitive stereotyped games which are considered "unstraight social interactions with others". Psychotherapy techniques are borrowed from a variety of sources: psychodrama, Gestalt therapy and others. TA is customarily conducted in groups of 8 - 10 people.

EXISTENTIAL PSYCHOTHERAPY

In the Existential perspective, a person's self-awareness is considered to be the most basic experience. The uniqueness and individuality of each human being, of each human existence is emphasized. Extential approaches emphasize actual, immediate, usually emotional experience as opposed to historical (developmental) determinants. This is close to the "self-actualizing" emphasis of some other psychological theories. A person is seen to change by existing differently. (There is an emphasis on 'authenticity,' making life and choices one's own.) Anxiety points to avoided possibilities of living. Authentic relating to others is stressed.

Eugene Gendlin's Experiential Psychotherapy is an example of Existential Psychotherapy. In this theory, it is believed that one can change oneself in present living. The person's past does not have to determine how one lives in the present. Experiential psychotherapy uses the theory of "felt concreteness". This is a "felt sense" of the complexities of a situation or a difficulty, not primarily emotion, words, or muscle movements.

Gendlin has developed four basic concepts of experiential psychotherapy: (1) "experiential felt sense" which is sensing the whole situation at a particular moment, including thousands of different aspects of a situation, all of them felt together, (2) "differentiation", the sorting out of the different facets of a felt sense, (3) "carrying forward", the bodily feeling when the right words for a felt sense have a physically felt effect - the body feels just a slight bit better because the words fit the felt sense, (4) "interaction" is a physical (bodily) interaction when we live our interpersonal, intellectual and spiritual situations within our bodies.

Family Therapy

DEFINITION OF FAMILY THERAPY

General Systems Theory and Communication Models

The foundation of family therapy, general systems theory is thought to have come out of the physics model introduced by Ludwig von Bertalanffy in 1945. Von Bertalanffy, a biologist, explored the principles of wholeness and organization and the dynamics of change. General systems theory and communication theory are usually the major concepts used in family therapy theoretical models.

A healthy family is considered to be an open system, and like all systems is subject to entropy. Entropy is the physical phenomena of matter moving towards disorder and disorganization with time. Applying this model to family systems, unless the family brings in new information and other kinds of stimulation from the outside, it suffers from entropy. Consequently, the "more closed off a family system is, the more entropic or disorganized it is likely to become." (Churchman, 1968) An open system receives energy from the environment and interacts with it. Using this new energy, it builds new structures and resists the entropic deterioration that occurs in systems that are closed off to outside stimulus.

Communications theory came out of the work of the "Palo Alto Group" that was made up of family therapy pioneers such as Bateson, Haley, Jackson, Satir, Watzlawick, Weakland, and their colleagues. As a result of their work they came to the conclusion that communication takes place at all times in a variety of ways. There is the overt level of words and a second layer of expression (metacommunication) such as voice intonation and body language which can be incongruous with the spoken word. When the two messages are not "congruent," internal and interpersonal friction occurs which can be experienced as confusion, anxiety or difficulty in the relationship with the other.

THE DEVELOPMENT OF FAMILY THERAPY

Many forces contributed to the shaping of Marriage and Family Therapy. Marriage counseling parallels family therapy and they have enriched one another.

Parents were brought into the treatment of emotionally disturbed children in the late 1930's and early 1940's. This phase is referred to as the child guidance movement. This move was prompted by an attempt to keep parents from interfering with the disturbed child's treatment.

Psychoanalytic theories and techniques dominated treatment methodologies in the early 1950's. Psychoanalysts began to notice that clients often had difficulty making personal change or maintaining it when they returned to the family environment. When families were brought into treatment there appeared to be change in the family dynamic and concurrent change in the individual that could not be linked to the individuals therapeutic work.

At the same time, the need for rapid psychological treatment for WW II victims, and the need for more clinicians than were available, pushed a move to alternative treatment modalities.

Family research done by the Palo Alto Group into schizophrenia and family communication patterns pointed to the possibility that the identified schizophrenic was involved in a "dysfunctional family system." They identified a "double bind" communication pattern in the family system which appeared to create an interactive neurosis. Over time this neurotic communication seemed to support the diagnostic identification of a schizophrenic family member.

OBJECTIVES OF FAMILY THERAPY

1. Short Term

Resolve any family crisis that has arisen.

Address problematic behavior of specific family members.

Reduce family stress or tension.

Clarify the problem.

2. Moderate Term

Bring the awareness to the family that they are a system.

Strengthen the marriage or executive system.

Clarify subsystem boundaries (i.e., Parents = Executive system; Children = Subsystem).

Deal with significant biosocial issues of family life, as in defining male and female and old and young roles.

Facilitate congruent communication of thoughts and feelings.

3. Long Term

Establish the boundaries of the family and their "world of experience."

Establish patterns of separateness and connectedness.

Restructure the family so the family system works toward planned change.

Establish cooperative problem solving.

Strengthen the entire family as a system.

Resolution of marital transference.

MAJOR CONTRIBUTORS TO FAMILY THERAPY

1. Nathan Ackerman

Author of *The Psychodynamics of Family Life* (1958) and *Treating the Troubled Family* (1966) is often called the grandfather of family therapy. Ackerman, a psychoanalyst, was the first to point out that successes in individual psychoanalysis were often destroyed when the patient returned to the family system. Ackerman's key concept was the social role and breakdown of role complementarity as an intervention. He advocated the breaking of family rules that maintain rigid patterns and negotiating new rules for more flexible interaction.

2. Gregory Bateson

One of the original members of the "Palo Alto Group," Bateson was an anthropologist and philosopher. He was interested in general systems theory. He identified the "meta-message" in communication and how the non-verbal information could be in direct contradiction with the verbal message.

3. John Bell

Author of the *Public Health Monograph* of 1960 and a founding father of marriage and family therapy. Bell used directive and structural techniques in the treatment of families with acting out or symptomatic children. His parental work included three phases - Parent-Centered Phase - Child-Centered Phase - Parent Child Interaction Phase.

4. Murray Bowen

Started as a psychiatrist specializing in psychotic children. Bowen partnered with Lyman Wynne at the National Institute for Mental Health (NIMH) on a research project focusing on schizophrenic families. Bowen coined terms such as, family ego mass, family projection process, and triangles. Bowen identified a differentiation scale, zero to one hundred which measured relative levels of emotionality and rationality. At 0, the person cannot separate thoughts from feelings and is completely at the mercy of their emotions. The perfect person would be completely free to respond, not react to feelings, establishing their own beliefs and goals on a rational basis.

5. James Framo

Works with couples, groups and families of origin. He sees each partner alone with their family of origin near the end of therapy to integrate intergenerational issues. Framo focuses on transferences that are made on to the partner and the therapist.

6. Jay Haley

One of the original members of the "Palo Alto Group" and author of *Strategies of Psychotherapy* (1963) and the *Power Tactics of Jesus Christ* (1969). Haley's background was in communications theory. Haley believed that relationships were based on a power struggle with each player struggling to define or redefine the relationship to fit their own needs. Haley focused on producing change in behavior through modeling new ways of relating. He pointed out metacommunications and ways to force the system to change using paradox, ambiguous directives, relabeling, and prescribing symptoms.

7. Don Jackson

One of the founding members of the "Palo Alto Group" and author of *Mirages of Marriage* (1968). Jackson was one of the first to apply systems thinking to family therapy. He identified (working with the Palo Alto Group) the "double bind" communication model which was thought to create schizophrenic children in families. Jackson's style focuses on not asking the abstract "why" but observing the current interactive "how."

8. Salvador Minuchin

Used an approach referred to as "structural family therapy." He wrote about his approach in *Families and Family Therapy* (1974). Minuchin's approach relied heavily on a technique called "coupling." He believed that this coupling or joining with the family led to the formation of a "therapeutic system." As the therapist became accepted by the family system he could then educate and model healthy behavior from within the system. He believed the healthier new behaviors would be accepted and adapted because the family believed in his genuine care for them. Minuchin developed the concepts of individual, spousal parental and sibling subsystems; subsystem boundaries; enmeshed boundaries; and rigid boundaries that prevent communication between subsystems. Minuchin's therapeutic goals were to make the family system healthier and more adaptive in their response to one another, family issues and problems.

9. Virginia Satir

Made communication and family systems theory popular for the general public. Author of *Conjoint Family Therapy* (1967), Peoplemaking (1972) and *New Peoplemaking* (1996). Satir is known more as a practitioner than a theoretician. Satir believes that self esteem is a basic drive in all people, and that low self esteem breeds faulty communication. She identifies "family pain" and describes five styles of communication and four types of family games.

A. Communication Styles

The first four styles are dysfunctional and the last one is the only functional style:

- **Placater** - the words agree, the body placates and the insides feel worthless
- **Blamer** - the words disagree, the body blames, and insides feel lonely
- **Computer** - the words are ultra-reasonable, the body is calm cool and collected and the inside feels vulnerable
- **Distracter** - the words are irrelevant, the body is off somewhere else, and the insides believe "nobody cares and there is no place for me."
- **Leveler** - in this model all pieces of the message go in the same direction and are congruent. The words match the body language. There are no or minimal threats to self esteem.

B. Family Games

- **Rescue games** - One member blames, the other placates, while another tries to distract the others from the distress of the interaction.
- **Coalition games** - two people join and agree while one family member disagrees with either one or both.
- **Lethal games** - everybody placates and agrees with others at the expense of their own needs.
- **Growth games** - each person includes self and increases self esteem while interacting with others.

10. Watzlawick

An Austrian and early member of the "Palo Alto Group" he focused on family communication. He used a brief treatment model with the goal being to reduce the client's pain through changing their behavior or the way they viewed their problems. Goals were identified in small, objective, obtainable steps so the client could begin to see progress in the problem solving process. The treatment plan usually consisted of:

A. Obtaining an objective definition of the problem and the behavior that supports it.

B. Devising a plan to create the solution.

C. Implementing the plan, revising as needed.

D. Terminating the case.

11. Carl Whitaker

One of the more irreverent founding fathers, he often risked the conventions of traditional psychotherapy. He has been identified as "driving families sane" by seeming to be more "mad" than they. His work with a co-therapist came out of a stressful setting at the pre-atom bomb Oak Ridge Hospital. Whitaker saw his role as a coach or surrogate grandparent. He began working with a family in a directive, structural manner and moved to a symbiotic relationship with them. He payed attention to unconscious processes and the transference phenomena. He insisted on the use of co-therapists to maintain perspective and objectivity. Whitaker's work is described in *The Family Crucible* (1977) written by his frequent co-therapist Augustus Napier.

12. Lyman Wynne

Focused on personality as being a subsystem of the larger family system. He worked with schizophrenia families at the NIMH. Wynne focused on the task of balancing identity needs with the need to be close. Wynne coined the term "pseudomutuality" to describe one rigid style of role relationship "a predominant absorption in fitting together at the expense of the differentiation of the identities of the persons in the relationship." He also used the term "pseudohostility" to describe a split or alienation which remains at a superficial level (like constantly criticizing Dad's cooking.)

13. Gerald Zuk

Calls his therapy a "triadic-based approach" and focuses on coalitions, alliances and the mediation processes. He is interested in the here and now process of the family. His goal is to break up pathogenic relating such as scapegoating, blaming, and labeling family member's behaviors.

SIMILARITIES AMONG FAMILY THERAPIES

What family therapists all have in common is their focus on the family as a system that impacts the mental health of it's individual members.

- They focus on strengthening the marriage relationship.
- As a rule family therapists tend to place more emphasis on changing patterns of interaction than on increasing understanding.
- They seek to help the family see itself as a system. They avoid identifying a single family member as a patient separate from the involvement of the family.
- They try to help the family establish a healthier "homeostasis" or balance including new levels of individual autonomy.

TYPES OF FAMILY THERAPISTS

1. Conductors

Conductors are active and directive in family sessions. They seek to create family member interaction by establishing a "star-shaped verbal communication pattern with themselves at the center." The therapist seeks to disrupt old dysfunctional communication patterns by forcing most of the messages through themselves. Their healthy modeling is made up of clear, open, unambiguous messages. Examples of conductors are:
Ackerman
Minuchin
Satir

2. Reactors

Reactors are less directive and focus on reacting to whatever the family presents.

A reactor subgroup called "analysts" use analytic concepts and often work as co-therapists. They observe their partner as they become enmeshed in the family system. Afterwards they analyze what it was like to be a part of the family and what it looked like to the observer. Examples are:
Whitaker
Wynne

3. System Purists

System purists focus on the changing communication patterns within families. They usually express less regard for their families change and growth. These clinicians and are more likely to use paradoxical prescriptions and premeditated interventions with the intention of forcing change by unbalancing the family homeostatic system. Examples are:
Haley
Jackson
Zuk

4. Coaches

Bowen's characterization of the family therapist's role. As a coach, the therapist supports the client in their movement toward greater health and individuation.
Bowen

MAJOR FAMILY THERAPY CONCEPTS

- The Family Life Cycle
- Family Secrets
- Family Mythologies
- Roles, Rules and Rituals
- Marital Transference

INDICATIONS FOR FAMILY THERAPY

A. The Presenting Problem is:

- Marital conflict
- Sibling conflict
- Intergenerational conflict
- Family violence

B. Any Individual Problem that affects other family members such as:

- Grief and loss
- Delinquency
- Teen pregnancy
- Chronic illness
- Substance abuse

C. Individual Therapy in which the individual does not seem to be making progress

D. Delinquency and Criminality

E. Problems with School Age Children

F. Severe Marital Discord and Impending Divorce

G. One Parent Families

H. Step Families

I. Schizophrenia

Common themes of schizophrenics in their families are:

1. The parents of schizophrenics are seen as immature, anxious and conflicted. They tend to use primitive mechanisms of defense.
   - Marital relationships are unsatisfactory
   - Family roles are rigid
   - Ways of meeting each others needs are disturbed
   - There is chronic family disequilibrium
2. The schizophrenic child is typically weak, sick, or in need of special care to begin with.
3. The process is transactional in nature. In other words, the schizophrenic is not an innocent victim but rather engaged in a reciprocal process in which each is both acting and being acted upon by others.
4. Outcomes of Family Therapy

   More general family implications are:

   - Improvement in one member of a dysfunctional family leads to disruption of the equilibrium of another and is resisted by the entire family unit.
   - Treatment of an individual needs to be extended beyond the identified patient.
   - Pathology in interaction can only be discovered by observing interaction directly. Transactions cannot be reconstructed on the basis of the individual dynamics of the several family members.

   The nature of the schizophrenic's family system is a result of the relationship each had with their parents. This leads to a three-generation model of schizophrenia and may apply to other syndromes as well.

CONTRAINDICATIONS

A. Key family members are not available via any contact media i.e., video conferencing or telephone.

B. Any family member is so disturbed the sessions end up focusing on their specific needs.

C. The family structure or marital relationship is so fragile that a direct focus would destabilize the dyad.

WHO IS SEEN

The family can be seen as a unit or any subset of that which includes individual members. The theory underlying this flexibility is that if any member of the family changes, they will impact and change the entire family system. Multiple families can be also be seen at one time.

FAMILY ASSESSMENT

A. **The family structure,** it's preferred transactional patterns and the alternatives available.

B. **The family system's flexibility** and its capacity for elaboration and restructuring as revealed by the reshuffling of the system's alliances, coalitions, and subsystems in response to changing circumstances.

C. **The systems resonance,** its sensitivity to the individual members' actions. The system ranges from enmeshment or extreme sensitivity to individual members input, to disengagement or extremely low sensitivity to individual members' input.

See assessments used in family therapy in the chapter on Assessment.

TECHNIQUES IN FAMILY THERAPY

1. Videotape and audio tape

Are used to assist the therapist and the client to see the non-verbal communication in the family. They help the family gain distance and see the patterns of communication in the system.

2. Family tasks

Focus on behavioral change and prescribe exercises for the family to practice at home or in the clinician's office. The tasks are designed to break up dysfunctional coalitions and increase healthy interactions.

3. Family meetings

Are helpful both as a diagnostic tool and an arena in which the family can practice new roles and communication skills. The executive system (parent/s) run the meeting and each family member has an opportunity to be listened to. Problem resolution and family planning are key foci of these recurring events.

4. Psychodrama

Helps increase the family members understanding and empathy for each others situation and feelings.

5. Geneograms

A geneogram is a multigenerational visual picture of a family tree which characterizes information about the relationships between family members as people, for example:

- Loving
- Difficult
- Angry
- Blocked

Other information can be included such as:

- Alcoholism
- Depression
- Other mental health syndromes
- Deaths
- Family violence or abuse
- Marriages
- Divorces
- Family secrets
- Family myths
- Communication styles
- or any piece of information that helps the client, or family understand what he/she has inherited from his/her family of origin.

6. Prescribing symptoms

The therapist predicts a family member's behavior creating the usual response to "reverse psychology" techniques. The symptoms then lose their autonomy and power.

7. Gestalt family therapy

Helps family members see problems in the context of the family system. Techniques include role-playing and family sculpting with the therapist taking a directive role.

8. Using multiple therapists

Using multiple therapists or co-therapists, working behind a one way mirror.

9. Non-Verbal Communication

There appears to be an inverse relationship between verbal and non-verbal expressions. Non-verbal expressions tend to occur in inverse proportion to verbal expressions that are ineffective, or fail to express true feelings. Family members who suppress their opinions tend to give vent to more non-verbal forms of expression than do family members who express themselves more fully in words.

Non-verbal expressions may give clues to attitudes or traits that are directly contradictory to expressed verbal opinions. If the therapist is guided solely by verbalized responses, they may often miss the crux of what is occurring in therapy.

The non-verbal expressions tend to act as hidden cues whereby the total family is prompted continually to re-enact miniature episodes of shared emotional conflict. This re-enactment of crucial role conflicts may have a cathartic effect and seem oriented toward the discharge of accumulated tension. However, its perseverative quality reveals a helpless, repetitive aspect that requires therapeutic intervention.

The therapist elicits suppressed opinions and attitudes of family members by direct challenge and confrontation of preconscious material. In addition, the therapist may pay particular attention to non-verbal expressions by calling attention to them and being able to reach and formulate some central aspects of the family conflict.

PHASES OF FAMILY THERAPY

1. **The engagement period** - lasts roughly the first four or five interviews. This is when the first critical issues occur between therapist and family.

2. **Working phase** - issues are worked out using the therapist's favored style.

3. **Termination** - occurs when therapist or family jointly or unilaterally decide that a satisfactory goal has been achieved, or a referral is made.

THE HEALTHY FAMILY CAN:

- Complete communication transactions
- Interpret hostility
- Consider how others see them
- Discuss hopes, fears and expectations
- Disagree
- Make choices
- Learn through experience
- Give clear messages that are congruent in their behavior
- Have a minimum of hidden messages
- Use "I" messages
- Allow members to be individuals
- Use direct communication (Gurman & Kniskern, 1990)

KEY CONCEPTS

1. **Accommodation** - focuses on the therapist's adjustments to the family dynamics in the service of "joining" with the family.
2. **Calibration** - a regulation of the system or family "thermostat." When the "comfort range" in a family is exceeded, the system attempts to recalibrate and return to its comfort zone.
3. **Conjoint Family Therapy** - coined by Jackson (1959), refers to joint interviews of members of the family with the identified patient.
4. **Detriangulation** - a rigid triad involving two parents and a child in which the parents allow any "deviant" behavior of the child to affect (distract or charge) conflicts they may be having.
5. **Diagnosis** - a working hypothesis of family system interactions as well as the diagnostic impressions of the individuals.
6. **Double Bind** - the dynamics of this communication pattern require two or more family members. It is usually a repeated message that creates a situation in which a family member has no behavioral option that does not end in a negative outcome. The message implies "if you do this you will be punished" and "if you do not do this you will be punished." There is no escape from punishment. The message may include a verbal command layered with a non-verbal actions, such as asking for affection and pushing the child away when they reach out. The receiver is not allowed to comment on the conflictual situation but must remain in the relationship in a double-bind state. Eventually the individual will internally replicate the double bind phenomena in non double bind situations.
7. **Emotional Divorce** - When both partners are emotionally immature and not able to be in relationship, one takes on the role of maturational adequacy while the other acts immaturely. The one who appears to be mature denies their own immaturity and functions the role of the mature one. They act together, yet are not in mature relationship together, thus an emotional divorce takes place. On the surface they may appear to be a happy couple but their experience is that they are alone.
8. **Equifinality** - "the same results springing from different causes." The final outcome of different stimulus resulting in the same event. An estranged couple may come together as the result of a child needing care due to an accident or an emotional attack from an in-law.
9. **Experiential Family Therapy** - the here and now experience, or "gestalt," of a family therapy session.
10. **Family Group Therapy** - joint interviews with several families present at the same time.
11. **Family Projection Process** - occurs when denied aspects of parents are projected onto the children. The children then become the holders of the family pain. Projection can be related to birth order. For example, if the mother was the first child, she may focus her pain on her first child.
12. **Homeostasis** - "the tendency for any system to react toward the restoration of the status quo" in response to any change.
13. **Joining** - the actions and reactions of the family therapist that are targeted to relating with family members or the family system as a whole.
14. **Maintenance** - the technique of providing support of the current family structure or dynamics.
15. **Martial Schism** - relationships in which there is a state of severe chronic discord and disequilibrium between the parents. Communication centers around power struggles, resistance, and the efforts to conceal or avoid facing the deep schism between the marriage partners or executive system. Having little to gain from each other, the parents seek support from the child. Since they are in competition for the child's loyalty, each attempts to diminish the worth of the other child. Schizophrenic females are believed to come from these systems.
16. **Martial Skew** - the relationship is skewed toward meeting the needs of one member of the executive system at the expense of the needs of others. Schizophrenic males are believed to come from these systems.
17. **Marriage Contract** - the known and unknown (withheld and unconscious) understandings each partner has about the marriage relationship.

18. **Mimesis** - accommodating to a family's style and emotional range mimicking their behaviors.
19. **Negative Feedback** - behaviors that restore the comfort zone in a family, i.e., a parents disapproving glance (the look) to an acting child.
20. **Non-Summativity** - "the whole is equal to more than the sum of its parts." When family is analyzed, there is more to look at than the individual members. There is the family entire family dynamic.
21. **Positive Feedback** - actions that upset the existing homeostatic balance to a family and forces the family system to a new, healthier state of equilibrium. The family may experience a new sense of community in a family therapy session and seek to replicate the behaviors that they believe created the experience in their family meetings.
22. **Tracking** - an accommodation technique in which the therapist follows the content of the family's communications and behavior and encourages them to continue.
23. **Undifferentiated Family Ego Mass** - Bowen refers to the "conglomerate of emotional oneness" that exists at various levels of affective intensity within the family. He believed it moved around within the family members and is seen in clearly defined and replicated patterns of emotional responses to stimuli. For Bowen, these responses are definitely different from the individual's autonomous response to a stimuli.
24. **Wholeness** - each part of the system, or family member, is related to the whole family. Individuals are impacted by the activities of each family member. A change in one person creates change in the other members of the family system, or the "whole."

Group Therapy

HISTORY

Group therapy has been around since humans first gathered around the fire and shared their innermost thoughts and feelings. It was seen in the Greek dramas historically and today when a number of people gather over a common theme. Groups serve the need for humans to be social and have a sense of belongingness. Clinically the origin points to a Boston physician Joseph Hersey Pratt. Pratt worked with tubercular patients in groups in 1907 and found that the group experience seemed to strengthen them to face their problems (Mullen, 1962). The use of group therapy increased after World War I and again after World War II when many soldiers, returning home with mental health needs, found limited resources. Groups were formed to serve them, not necessarily because it seemed to be the best approach. But here again, counselors found that talking about their experiences in groups appeared to help the soldiers face the problems they were dealing with after their traumatic experiences. In Europe Alfred Adler formed "therapeutic communities," and Trigant Burrow, a student of Freud, observed group behavior in camp retreats. In the 1930's Paul Schilder of New York identified the transference process of group members onto their group leader. Jacob Moreno began working with groups in 1907 but did not coin the term "group psychotherapy" or "psychodrama" until the 1930s. One of the more recent popular group styles was the "encounter group" of George Bach. These groups met nonstop for 20 hours or more. The rationale was that the constant stimuli broke down the defenses and facilitated honest communication and personal insight. Today there are many types of groups that are treatment alternatives for clinicians.

ADVANTAGES OF GROUP THERAPY

- Social learning
- Social support
- Safe place in which to try out new behaviors
- Safe environment in which to confront others
- Social arena in which to try out new roles
- Sense of belongingness
- Safe place in which to practice new social skills and styles
- Spreads out the counselor's expertise in schools and agencies
- Lower cost of therapy per individual

TYPES OF GROUPS

The general goals of group therapy for a client are: trying out new social and relational skills, developing a responsibility for others and increasing self-awareness. More specifically identified groups present more specific goals. Many theoreticians have created groups based on their theoretical models dynamics. The following is a list of the more well known group formats. There are many more.

1. Activity Groups

These groups are helpful for both adults and children. The members jointly select an activity and learn about the decision making and negotiating process as they engage in the activity.

2. Client-Centered Group - Carl Rogers

Goal	Wholeness and self-actualization.
Process	Increasing self understanding and the alteration of self concept.
Focus	Insight and affect oriented.
Leader	Group member centered and process oriented.

3. Confrontational Groups

This kind of group is often used on locked psychiatric units. Group members are confronted with their aberrant behavior in a direct, clear manner. Since the client does not stray outside the therapeutic community, support systems are in place to deal with reactions to the confrontation.

4. Discussion Groups

Group members discuss issues in the presence of a leader mostly on a cognitive basis, but with some emotions emerging. Examples are schools, camps, training programs and any facilitated discussion group.

5. Eating Disorder Groups

There are many different types of eating disorders and settings in which eating disorder groups meet. Screening for medical problems and Axis II diagnosis is important. The goals of the group influence the screening criteria. The three main types of groups are (1) psychoeducational (2) inpatient and (3) outpatient which requires high motivation and interactional skills.

6. Encounter Groups

The primary emphasis of the group is on individual expression and recognition of affect. Carl Rogers used this term in the 1960's to describe a humanistic and growth oriented approach.

7. Existential Group Therapy

Patients are confronted directly about their dysfunctional behavior. Transference and the therapist's countertransference are examined.

8. Functional/Industrial Groups

These groups are usually task directed. The group is composed of work units or departments and may include both management and line staff. Ad Hoc groups are usually formed temporarily for a strategic purpose.

9. Gestalt Groups - Fritz Perls

Goal	Awareness of the here and now, personality change and finishing unfinished business.
Process	Articulating the experience of the here and now, working with the group leader in the "hot seat" to bring personal issues to the forefront, sometimes involving personal catharsis.
Focus	Action/insight and emotions.
Leaders role	Group member centered when leader is not working with someone in the hot seat, process oriented.

10. Marathon Group

An extended one session group, 20 hours or more.

11. Psychodrama Group

Originated by Jacob Moreno, psychodrama incorporates role playing, makeup, interpersonal relationships, conflicts and emotional issues into Moreno's model. A dramatization includes the protagonist or patient who acts out the problems; alternate egos, people who enact different aspects of the patient; the audience and the director, or therapist, who guides the players towards new insights. The goal of the psychodrama is to bring awareness and reframe the individuals' perceptions of the event/s. Being immersed in the event allows for catharsis, insight and reality testing.

12. Psychodynamically Oriented Group

Therapists who offer psychoanalytically oriented group psychotherapies do not suppose that the outcomes will be identical with those of classical analysis but assume that the interactions between the members of the group, when focused on, will provide the kinds of insights that take place in individual work.

Goal - to restructure the client's character and personality.

13. Process Oriented Group

Process oriented groups recreate, analyze, discussing and interpreting while working through personal and interpersonal issues.

Focus	Insight and affect oriented.
Leader	Leader centered and process oriented.

14. Rational-Emotive Group - Albert Ellis

Goal	To create constructive changes in the client's thinking and behavior leading to greater acceptance of self.
Process	Learning the ABC theory of (A) practicing, (B) disputing and (C) exercising, self discipline while addressing irrational beliefs and values.
Focus	Is on action/insight and rational oriented behavior.
Leader role	Leader centered and both process and outcome oriented. Therapist is viewed as a teacher rather than a therapist whose task is to help eliminate self-defeating behaviors.

15. Self Help Group

Self help members usually have a common problem and come together to "get better" with the support of others. There is more of a focus on personal responsibility and active working on problems than is done in support groups.

16. Support Group

Groups like Alcoholics Anonymous (AA) support the idea that the individual has potential goodness and will achieve resolution of his/her problems when working with and being supported by people with the same issues.

17. T Groups

T Groups or training groups grew out of the field concepts of Kurt Lewin in the 1930's and 1940's. His work became the basis of the Tavistock Small Study Groups in Britain. The focus of this group is to examine and improve interpersonal skills. How one functions within a work site group is examined.

18. TA Groups - Transactional Analysis - Erik Berne

Goal	Awareness, making new decisions and altering the course of life.
Process	Interacting with others and identifying the role you play in these interactions based on the TA model of Parent, Adult and Child ego states.
Focus	A combination of insight/action and rational affect oriented.
Leader	Leader centered with equal process and outcome orientation.

19. Therapeutic Community

A therapeutic community is one which is sensitized to the feelings and needs of the patients. This community can be made up of lay people or professionals, or a blend of the two.

GROUP STRUCTURE

1. Size of group

A. Treatment Groups

Many experienced group therapists recommend seven to nine members. This allows for a wide range of diversity in the make up of the group and allows for enough time for group members to experiment with a new range of defenses, emotions and new interaction skills.

B. Discussion groups, supportive groups, activity groups and social groups permit a larger membership.

C. Marathon groups often contained more than 20 members.

D. A therapeutic community includes every member of the community.

2. Types of group members

All groups should share the same agenda and group expectations. In general, heterogeneous groups are the preferred working model.

A. Heterogeneous

These groups offer more variety and creative ways of looking at problems. Mixed groups are usually the most effective, but occasionally a group member is so different that he/she skews the group into dealing with his/her differences rather than the agenda the group came to work with.

B. Homogeneous

Homogeneous groups can be effective for problem solving. People with similar backgrounds or current life phases or situations can validate one another's experiences and identify common problems more quickly than a mixed group.

3. Closed versus Open Groups

Closed groups do not allow new members. This does deprive the members from dealing with the process of integrating a new member to the group family. However, with open groups, if the member policy is too open-door, new people will arrive and leave too quickly for cohesion to develop and the group process will not proceed in a helpful way.

4. Group Communication Structures or Sociograms

Group Communication Structures or Sociograms are used to identify or map group member's interactions and choices about interpersonal relations within the group.

5. Frequency of sessions

Most groups meet weekly to maintain continuity and focus of group members. Marathon groups often meet only once and discussion groups need only meet when the issues demand.

6. Screening Group Members

Each member needs to be screened before he/she enters the group to ensure an appropriate fit. Some of the areas that a screening should focus on are:

- History of the family of origin
- Medical history
- Diagnostic history and a sense of where the client stands on the continuum of the illness and wellness in relation to their particular diagnosis
- Level of psychological education
- Ability to set personal boundaries
- Ego strengths and defense mechanisms

GROUP MEMBERS RIGHTS

Informed consent - the client is told before the group about his/her rights and expectations of group members. Members must receive this information individually before group counseling begins so each one can make an informed decision to join or not to join. If the client is not given this information until he/she is a part of the group, and then does not want to abide by the guidelines, he/she will find it difficult to exit the group, which is more difficult than breaking contract with the therapist. Ideally, this information is in writing and is signed by the new group member. A copy is kept by the group leader and a copy is given to the group member.

Rights included in the informed consent must include but are not limited to:

- Confidentiality
- Freedom From Undue Pressure
- Participation Is Voluntary (If It Is)
- Freedom Of Exit (If There Is Not A Commitment Requested)

GROUP STAGES

There are different descriptions of the group stages by theorists. They all seem to have similar process, starting with the beginning phase of checking other members and the leader out and finding their place, the middle or working phase, and the final or termination phase. Different stage models follow:

1. Coreys Stages

A. Orientation and Exploration

The issues are inclusion, identity and trust. The leader provides his/her expectations about honesty and spontaneity.

B. Transition

The issues are anxiety, conflict, resistance. The leader may be challenged by members. The leader's task is to create an environment that is supportive while dealing with member anxiety and trust issues.

C. Working

The issues are cohesion and working as a group. The group can now depend less on the leader. Group members self-explore more on their own. The leader's tasks are to maintain support, model healthy behavior, and help members translate insight into action or behavior change.

D. Consolidation and Termination

The issues around ending and loss are now on the table including feelings about leaving, unfinished business and preparing to take what they have learned in the group outside. The leader must deal with emotions, support change and help members move into their individual futures.

2. Rogers Stages The Transition Process Of Groups From Orientation To The Working Stage

- First - Milling around.
- Second - Resistance to personal expression. The group leader needs to take charge and give some direction and/or modeling.
- Third - Beginning to express feelings. Often this begins with past feelings. The group leader can help members stay present and express current feelings.
- Fourth - Express current negative feelings.
- Fifth - Daring to take risk and explore present feelings as the members get to know one another better.
- Sixth- Periods of silence begin to occur which the group leader must manage and decide when to allow them and when to intervene.
- Seventh - Spontaneous responses to feelings and behaviors, both positive and negative.
- Eighth - Members begin to accept themselves and think about what they like and do not like and want to change.
- Ninth - Members begin to accept confrontations as helpful feedback rather than perceiving them as attacks.
- Tenth - A closeness is developed by the group.
- Eleventh - Behavioral changes occur in group members.

3. A Model For Psychodynamically Oriented Groups

A. Beginning Phase

The client's prime conflicts, transference feelings, emotions and concerns from the past often arise around the issue of inclusion. Each member wants to know at some level whether he/she will be accepted by the leader and the group, where he/she stands in relation to popularity and to what degree others will show tolerance or aggression.

B. The First Meeting

A counselor can begin with as few as four or five patients and add other members gradually if it fits the group model the counselor is using. The first meeting is a good time to tell everyone about the group rules concerning arrival, confidentiality, breaks, letting the group leader know if they will miss a session and any other rules the group leader believes are important. It is important that all members hear these rules together so everyone knows everyone else was told the same information. On the other hand psychoanalytically oriented practitioners sometimes are interested in increasing anxiety at the start of the group by not sharing any information and observing the group member's defensive structure.

C. Middle Phase

Transition stage - dealing with resistance. The main issue here is often power struggles with the main questions being: Can I exert or maintain control? Can I challenge the authority of the leader? This phase resembles the enmeshment of infancy and individuation of the adolescent. Often times the group leader observes negativity or rebellion in group members.

D. Later Phase

The group matures and parallels successful separation and individuation. Group members model healthy interdependency and respect each other's separateness while sharing intimacy.

E. Termination

- Appropriate - leaving a group or having the group end is a good time to deal with themes of loss and letting go. The counselor can orchestrate the group experience by bringing up the issue of termination and addressing the feelings of sadness and loss of the support of the group. Several meetings are needed to deal with the issues that arise.

- Premature - often occurs because the client cannot master his/her anxiety or other issues and choses to leave (flight) rather than deal with the issues. It is up to the group leader to decide what to do about this event about the person who has left, and of course to deal with the feelings of the group members who remain.

4. The Five Stage Model

- Forming
- Storming
- Norming
- Performing
- Mourning

5. Yalom's Stages

- Orientation
- Conflict
- Cohesion
- Termination

LEADERS IN THE FIELD

1. Jacob Moreno

Jacob Moreno created the "theater of spontaneity" in Vienna in 1921, the birth place of psychodrama; which emphasizes the acting out of conflicts or crisis in the here and now. Moreno was also the founder of the American society of group psychotherapy and psychodrama.

2. Irvin Yalom

A. **Irvin Yalom identified eleven 11 curative factors which exist in successful group work.** He believed that if these factors were present, participant growth and development would occur.

- Altruism
- Universality
- Interpersonal learning
- Imparting information
- Development of socializing techniques
- Imitative behavior
- Group cohesiveness
- Catharsis
- Family reenactment
- Institution of hope
- Existential factors

B. **Leadership functions that needed to be present separate from any theoretical orientation:**

- Emotional stimulation that encourages the expression of feelings, values, beliefs and deep emotional concerns.
- Confrontation, challenge, self-disclosure, and modeled behaviors.
- Caring which is expressed through genuine warmth and acceptance.
- Honesty and the promotion of openness and trust.
- Meaning attribution - provided by the leader's cognitive understanding of the events in the group which they articulate to group members.
- Interpretation, clarification and use of self responses which are objectified and articulated.
- Executive leadership function - the leader sets the structure through limits, norms and direction.
- Pacing, blocking, stopping and managing the group as a social system.

C. **Yalom found that effective leaders used moderate amounts of emotional stimulation and executive direction.** Frequent use of caring functions arose along with a consistent use of meaning attribution.

D. **Yalom found that ineffective group leaders showed very low or high emotional stimulation and executive behavior, low caring modeling and low use of meaning attribution.**

3. Zander Ponzo

Zander Ponzo's work came out of his study of Yalom's factors. Ponzo added some skills of successful group leaders to Yalom's list:

- Openness
- Participation
- Risk-taking
- Conflict-confrontation
- Caring support

CO-THERAPY

Two or more therapists lead a group together. Depending upon the group, it may be helpful to have a male and a female leader. Co-leaders should have a good working relationship and theoretical orientations that work collaboratively. If the leaders engage in a power struggle, it will not facilitate group health. Co-leaders should process the group experience regularly. This is also an excellent way to train new group leaders. Advantages are:

- Objectivity - each group leader can observe and provide feedback to their co-therapist.
- Co-leaders can role model and model linking when possible.

GROUP LEADERSHIP SKILLS

1. **Active listening -** hearing, understanding and communicating that one has heard the other's message.
2. **Blocking -** intervening without attacking anyone when a member begins to engage in counter productive behaviors such as scapegoating, storytelling, or gossiping.
3. **Catharsis -** coined by Yalom, being able to freely express feelings inside the self.
4. **Clarifying -** focusing on underlying issues and assisting others to get a clear picture of what they are thinking and feeling.
5. **Confrontation -** challenging members in a direct way on discrepancies and in such a manner that they react non-defensively.
6. **Empathy -** intuitively sensing the subjective world of others. Being able to adopt the frame of reference of others, and communicating this insight.
7. **Facilitating -** helping member's clarify their goals and subsequently take the best steps to reach them.
8. **Goal setting -** helping group members work cooperatively so that there is an alignment between member goals and group goals.
9. **Initiating -** demonstrating an active stance in intervening in a group at appropriate times.
10. **Linking -** looking for themes or common issues and connecting them in a way the group members can understand.
11. **Interpretation -** explaining the meaning of behavior patterns or verbal exchanges.

12. **Modeling** - demonstrating healthy behaviors to members .
13. **Protecting** - intervening to ensure that members will be safe from unnecessary psychological risks.
14. **Questioning** - using questions to stimulate thought and action but avoiding a question answer pattern of interaction between leader and member.
15. **Reflecting feelings** - mirroring what others appear to be feeling without being mechanical.
16. **Restating** - capturing the essence of what is said in different words using affect to add meaning or clarify meaning.
17. **Self-disclosure** - sharing with group members personal information or personal reactions that relate to the here and now occurrences in the group.
18. **Summarizing** - pulling together loose ends, identifying common themes, and providing a picture of the process trends of a group session.
19. **Support** - offering positive reinforcement to facilitate change.
20. **Use of silence** - holding back responses or interventions and listening to the dynamics of the group during and after a period of silence.

INDICATIONS FOR GROUP THERAPY

1. Trying out new relationship skills in a safe environment
2. Working on relationship issues with the guidance of a therapist
3. Isolation
4. Learning new coping skills from others with similar problems

CONTRAINDICATIONS FOR GROUP THERAPY

1. Poor Ego structure
2. Loose personal boundaries
3. Personality disorder
4. Serious problems that could become the focus of the group
5. Extremely low relationship skills

IMPORTANT GROUP THERAPY CONCEPTS

1. **Abreaction -** bringing about an awareness and expression of emotions previously blocked from consciousness.
2. **Cohesion -** develops as group members begin to share feelings toward each other and the group leader. Members work to solve a common problem and share the desire to build a social structure that resembles an ideal healthy family.
3. **Group dynamics -** the therapist's understanding and interpretation of group behavior as a whole furthers the development of all individual patients. The part the individual plays in these interactions helps them understand their social needs and habits.
4. **Group themes -** according to Bion (1951) three major topics overshadow all others, dependency, fight-flight, and pairing, that parallels the group dynamics of inclusion, power and intimacy.
5. **Group norms -** A set of group rules of behavior either overt (formal) or covert (informal) which provide limits to behaviors. These rules may parallel or be different from the outside world. There may be overt or covert pressure on members to conform to the norms and there may be the rebellious type who seek the norms so they will have something to rebel against. These group members begin the process of setting consequences. An example of a group norm would be a particular level of self disclosure or expression of emotions such as crying.
6. **Identification -** in the group setting the patient learns new modes of adaptation by identifying with certain qualities of the group members.
7. **Intellectualization -** a cognitive awareness of oneself, others, and various life experiences that account for the members current functioning.

CHAPTER 7

Treatment Modalities

1. Family Therapy

Therapy consists of the therapist or therapists meeting conjointly with members of a family where one or more members is showing dysfunction in order to help the entire family function more adequately. The theoretical techniques used differ depending on the theoretical orientation of the therapist(s). The theory and techniques of family therapy are discussed more thoroughly in the section on Family Therapy.

2. Group Therapy

Group Therapy is used when a group of clients, each experiencing some form of interpersonal dysfunction, meet conjointly with a therapist or therapists. The interaction of group members with each other and the leadership of the therapist(s) helps facilitate changes in self-esteem, behavior, ways of thinking and interpersonal growth. Group Therapy is discussed more thoroughly in the section on Group Therapy.

3. Individual Therapy

A. Brief Treatment

Brief Treatment is characterized by a limited number of interviews, usually 10 - 15, agreed upon with the client in advance or mandated by the Health Maintenance Organization (HMO) or insurance company. Brief treatment concentrates on current problems, only rarely touching on transference issues unless they are negative and seldom deals with character problems. Dependency and regression are discouraged in this mode of treatment, with the therapist taking a more active role in determining the focus of interviews than with longer-term treatment. Brief treatment is the treatment of choice for many clients, especially those in acute crisis who are not interested in reorganizing their character structures. Persons who are somewhat psychologically-minded can also benefit from

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brief treatment. These clients need to be able to look at themselves realistically, they need a strong ego, they need to be in a favorable reality situation and be able to work well with the therapist.

Managed Care companies often pay for even fewer therapy sessions (ex: up to 6 sessions). Companies may honor requests for some further sessions, if prior approval is obtained. This mode of therapy is very focused and extremely limited in scope.

Theoretical orientations often used in Brief Treatment are: the Cognitive, Cognitive-Behavioral, Behavioral and Social Learning therapies (ex: Skinner, Glasser, Beck, Bandura, Ellis). However, psychodynamic theories are also appropriate when used with limited and focused goals.

B. Moderate and Long Term Therapy

Moderate and Long Term Therapy attempts to understand and modify human behavior using the psychological methods of confrontation, clarification and interpretation. These modes of therapy tend to focus on underlying issues, not just on behavior and are generally more psychodynamically oriented. Thoughts and feelings are of central importance and overt behavior is understood in terms of inner psychological processes inferred from the client's words and actions. Therapy is completed when the client's goals have been met or the client's functioning is improved enough that he/she feels able to "be on my own". Lifetime maintenance may be necessary for some severely disturbed clients. The number of sessions is not specified in these therapies.

Theoretical orientations used in Moderate and Long Term therapy are the Psychodynamic theories, Psychoanalysis (ex: Horney, Sullivan, Jung, Anna Freud, Hartmann, Rapport, Erikson), Humanistic therapies (ex: Perls, Rogers, Berne), Existential therapy.

4. Crisis Intervention

A crisis is defined as a precipitating event that is time-limited and disrupts a person's usual coping and problem solving capabilities. It can be situational, for example, natural disasters, loss of a job or an assault or it can be maturational, such as the marriage, birth of a child or retirement.

A. Disorders appropriate for a Crisis Intervention focus are: severe depressive reactions, acute psychotic states, hyperactive excited states, acute anxiety, panic reactions, acute hysterical reactions, intoxication, severe fear or hysteria resulting from a physical or sexual attack, separation anxiety, fire setting, grief and bereavement (Goldenberg, 1983).

B. Stages of usual reactions are:

1. **Shock** (denial), inability to integrate information, the tendency to "shut down" psychologically which gives the person time to integrate the full impact of the situation, gather inner resources and obtain support. Strong emotional outbursts are common in this stage.

2. **Realization or recognition** of the crisis and finding ways to solve it. This is the peak of the crisis with feelings of helplessness, vulnerability, and instability. This stage may include periods of denial and may last several months, depending on the severity of the crisis.

3. **Integration,** including emotional and intellectual assimilation of the crisis.

C. **Treatment goal** in crisis intervention is to reach the people in acute state of stress and provide them with enough support to prevent them from becoming the 'chronics' of the future (Phares, 1988).

1. **Substages in treatment** to be addressed by all types of crisis intervention are:

    a. Relieving the client's symptoms
    b. Restoring the client to her/his previous level of functioning
    c. Identifying the factors that precipitated the crisis
    d. Identifying and applying remedial measures (Rapaport, 1970)

2. After the crisis has passed, the therapists may be able to help the client connect current stresses with earlier life experiences thus helping the client develop adaptive coping skills that can be used with future problems.

D. **Treatment techniques** depend on the nature of the crisis and generally involve one or more of the following:

1. **Environmental manipulation** where the therapist directly or indirectly removes the identified hazard from the client's environment (ex: by making appropriate referrals).

2. **General support** where the therapist provides the client with emotional support using a variety of techniques (ex: active listening).

3. **Generic approach** where the therapist utilizes conventional crisis intervention techniques appropriate to the client's crisis.

4. **Individual approach** where the therapist uses interventions appropriate for a specific person. Use of an individual approach is based on the assumption that the crisis and the person's reaction are related to long-term personality dynamics.

CONFLICT RESOLUTION/MEDIATION

Mediation is voluntary participation in a structured process in which a neutral third party assists two or more disputing parties who are trying to reach an agreement. The mediator acts as a facilitator, helping the disputants work together to identify common interests. It is the responsibility of the disputing parties to make recommendations, to determine the final decision and to find mutually agreeable solutions.

A. **Characteristics of mediation are:** confidentially, acceptance, active listening, development of rapport and empathy, interpretation of the interactive dynamics, role modeling, and emphasis on the present and future.

B. **Basic components of mediation are:**

1. **Intake and Orientation** consists of establishing rapport and structure, attending and active-listening techniques are used.

2. **Joint Sessions** is where each party tells his/her own story in the presence of the other. Problems and goals are defined and information is gathered regarding positions, needs, and interests. Reframing is part of the process.

a. **Individual Sessions** may be necessary to continue to build trust, to explore options, to reinforce the client and to discuss the client's positions, needs and interests in more depth than before.

b. **Mediator** caucuses may be required, if more than one mediator is involved, to discuss strategies.

c. **Agreement** results when the disputants are brought together and a contract is presented and signed. A follow-up contact may be required to reassess the agreement (Messing, 1993).

CHAPTER 8

Special Treatment Issues

CHILD ABUSE AND NEGLECT

1. Definition:

Definitions of child abuse and neglect differ. Incidence estimates vary widely from 60,000 to 1.5 million children. In Massachusetts and many other states counselors are Mandated Reporters of child or elder abuse or neglect. Under penalty of law, Mandated Reporters must report suspected abuse or neglect to the appropriate agency.

2. Characteristics of abusive parents

A. General:

1. Although a few abusive parents have severe mental illness, the large majority show only maladaptive personality characteristics and behaviors. Some behaviors that have been associated with high risk for child abuse include emotional immaturity, as evidenced by low impulse control and frustration level, a tendency to over-react, and high dependency needs. Abusive parents often place a high value on authoritarianism, are highly rigid, and have low self-esteem. Additionally, these parents often experience few pleasures in their life and often abuse drugs and alcohol (Blumberg, 1975; Steele, 1975 as cited in *Preparatory Course for the Psychology Licensing Examination*, Vol. IV, 1991).

2. The social isolation of abusive parents has been documented. This isolation results in few sources of emotional support including that of their own parents, since there is often a poor relationship with their parents. Abusive parents have also been found to move from place to place frequently (Green, 1976).

3. Other parental factors for possible child abuse are a strong belief in the value of physical punishment for controlling behavior, a view of children as their "property", there may be marital conflicts and instability and a history of minor criminal offenses. Abusive parents are generally between 20 - 30 years of age, having married at a young age and been young at the time of the birth of their first child (Cameron, 1994; DeFrancis, 1963; Steele & Pollack, 1974, Komisaruk, 1966).

4. The lives of children are often disrupted by moves to escape domestic violence. Thus, they frequently lose considerable school time; must leave home without books, money or change of clothing. They may live in the family car if shelters are not available. They may suffer from depression, have difficulty concentrating, be distracted or frequently spend time "daydreaming". They may "act out" toward their parents or siblings (*National Coalition Against Domestic Violence*, 1996).

5. More than 350,000 children in the United States in 1990 were abducted by parents. Over half of these abductions were short-term manipulations involving custody issues. Almost half involved concealing the whereabouts of the child or taking the child out of state (*National Coalition Against Domestic Violence*, 1996).

6. Some abusive parents have been seriously abused as children, while others have experienced other forms of deprivation, hostility or rejection. Abusive parents may have endured a lack of early nurturance or experienced the loss of a significant parental figure as a child (*Preparatory Course for the Psychology Licensing Examination*, Vol. IV, 1991).

7. Parents abused as children but who are not abusive as parents generally have a greater involvement in social and religious groups and a greater willingness to seek outside support and assistance when needed. They generally have a greater spacing between the birth of their children and may also have intense empathy with those in pain (Hunter, et. al., 1978).

B. Gender and Socio-Economic Class:

1. Several investigators report that mothers are the most common perpetrators of physical abuse, while it is generally the father who is most often the perpetrator of sexual abuse. (*National Coalition Against Domestic Violence*, 1996). Although low income groups are over-represented as abusive parents, it is probably because in their greater use of public social service agencies and hospital emergency rooms, where the abuse is more likely to be reported. The private physicians, who are more likely to see higher-income groups, are less likely to report child abuse. Poverty and associated factors, not ethnicity, are seen to lead to higher rates of child abuse (Elmer and Gregg, 1967).

2. Child abuse knows no economic or ethnic boundaries.

3. The abused child

A. Misperceptions of the child are common among abusive and neglectful parents.

These misperceptions include: unrealistically high expectations, inaccurate perceptions of the child's needs and inaccurate perceptions of normal development (*National Coalition Against Domestic Violence*, 1996).

B. Birth Problems:

Higher rates of physical abuse have been found in children who had a difficult birth or those who were born prematurely (Elmer and Gregg, 1967; Lynch, 1975; Skinner and Castle, 1969 as cited in *Preparatory Course for the Psychology Licensing Examination*, 1991).

C. Abused children may exhibit particular attributes, but it is unclear whether these characteristics are the effects or triggers of maltreatment. However, compared to non-abused children, abused children display higher incidence of:

1. mental retardation
2. medical illness
3. physical deformities or handicaps
4. delay in speech, motor skills, social development
5. hyperactivity
6. hypervigilence
7. pathological aggression
8. oppositionalism
9. disobedience
10. antisocial behavior
11. fear
12. immaturity
13. low self-esteem
14. impaired ability to enjoy life
15. withdrawal
16. seductiveness
17. exhibitionism
18. sexualized play
19. other sexualized behavior
20. Post Traumatic Stress Disorder (PTSD)
21. Conduct disorders - sexually abused boys may develop Conduct Disorder with lying, stealing, vandalism, assaults on other children (*Preparatory Course for the Psychology Licensing Examination*, 1991)

4. The consequences of sexual abuse

The consequences of sexual abuse are more severe when the abuse occurs at a younger age, is repeated, involves the use of force or physical penetration and is incestuous. The response of the nonabusive parent is very important to the child. The child victim of incest is more seriously affected than other trauma victims. They feel helpless, betrayed, stigmatized and contaminated. When victimized girls become adults, they may allow themselves to be further abused by men physically and sexually and accept degradation as the price of intimate relationships. Boys are more likely to admit feelings about their sexual abuse than are girls. Families are more likely to blame boys for being sexually abused and to deny any serious effects of the abuse (*National Coalition Against Domestic Violence*, 1996).

Overall maltreatment is about equal in girls and boys, the difference being in the pattern of maltreatment. In young children, boys are more common victims of physical abuse whereas in adolescence, girls are more frequently abused. With sexual abuse, young girls and older boys are the most common victims. Girls are the victims of sexual abuse about ten times more often than boys (Brown and Finkelhor, 1986).

DOMESTIC VIOLENCE

1. Scope

Domestic violence is widespread. Domestic violence includes verbal, emotional and physical abuse. The U.S. Justice Department found in 1994 that women are ten times more likely then men to be victims of violent crime in intimate relationships. Women generally resort to violence only to protect their children or to protect themselves. Statistics show that domestic violence is the leading cause of harm to women between 15 and 44 years of age, eclipsing muggings, stranger rapes and automobile accidents combined. Injuries that battered women receive are at least as serious as injuries suffered in 90% of violent felony crimes, yet under many state laws, they are almost always classified as misdemeanors.

In 1991, more than 90 women were murdered every week. Nine out of ten were murdered by men. In 1995, in the United States, a woman is beaten by her husband or partner every 7.4 seconds. More than 50,000 women in the United States seek restraining or protection orders every month. Of all homeless women and children, fifty percent are fleeing domestic violence. More than three million children witness acts of domestic violence every year and more than half of the abused women who are mothers beat their own children. The children of abused mothers are six times more likely to attempt suicide and fifty percent more likely to abuse drugs and alcohol.

2. Perpetrators

Battering men come from a variety of backgrounds. Compared to other men, men who batter are more likely to: have grown up in a violent family, blame others for their problems, tend to use force to "solve" problems, abuse alcohol and/or drugs, think poorly of themselves, hold strong traditional ideas about what a man should be and what a woman should be, are jealous of their partner's friends (including other men as well as women and family members), play with or talk about using guns, knives, or other lethal instruments to "get even", expect their partner to follow their orders or advice, go through extreme emotional highs and lows, be frightening when angry, treat their partner roughly. Battering men often have a paranoid, borderline, narcissistic or antisocial personality. Their abusiveness may be confined mainly to the home and they can be very sensitive to the realities of status and power. They can thus appear charming and affable (for example, at work) or deferential and sometimes pathetic in the presence of professionals or the outside world.

Thanks to: National Coalition Against Domestic Violence, Denver CO and Women's Crisis Center of Greater Newburyport, Newburyport, MA for information in this section.

3. Battered women

Flynn (1975), as cited in *Preparatory Course for the Psychology Licensing Examination*, (1991) has identified several "subtypes" of abused women.

A. The relationship with their abuser (generally husband/partner) is relatively stable, with infrequent occurrence of abuse, which is rationalized by being attributed to alcohol or external causes. They may initiate violence toward their partner.

B. The relationship with their abuser is highly unstable, and the abuse includes a sexual component. They are the most severely abused.

C. These women are most likely to be living in constant fear, generally do not retaliate, least likely to have a history of parental or previous spousal abuse, experience the most chronic and severe forms of physical abuse, the children are most likely to also be victims of the abuser.

D. These women experience the lowest frequency and severity of abuse, which often includes a sexual aspect, the children are likely to also be victims of the abuser. These women are the most likely to report their intention to return to their partners, but are among the least likely to do so.

E. These women tend to experience violence as part of their lives, having an extensive history of violence in their families of origin. These women may continue to live with their abuser.

Abused women may believe they "deserve to be hit" and they may stay in the situation because they love their husband or spouse.

SUICIDE

1. Emile Durkheim

The first major contribution to the study of suicide was by Emile Durkheim. His thesis is that suicide, like crime, neurosis, and alcoholism, is a factor that measures social pressure and tension. He divided suicide into social categories: (1) egoistic - those assumed not to have been strongly integrated into any social group, (2) altruistic - those whose proneness to suicide stemmed from their excessive integration into a group and (3) anomic - those who experienced a disturbance in the balance of their integration with society that leaves her or him without their customary norms of behavior.

2. Current treatment approaches

A. No accurate way of predicting suicide has been found.

Previous suicide gestures is the best indicator of risk. Other indicators are: previous or present suicidal ideation, "getting life in order", giving away items special to the person, feelings of a high level of hopelessness or deep depression.

B. Adolescent Suicides

Adolescent suicides are not necessarily committed for the same reasons as those of adults. Adolescents may overreact to small frustrations and are likely to be deeply depressed. Signs of depression in adolescents are difficult to recognize, but may include sadness and hopelessness masked by boredom, apathy, hyperactivity and physical complaints.

C. Types of suicides in adults identified by J. Baechler (1979) are:

1. **escapist suicides -** flight (despair, hopeless), grief (loss of central element in life), punishment (self-loathing)

2. **aggressive suicides** - crime (kills another, then self), vengeance (to induce guilt), blackmail (coercion), appeal (cry for help)

3. **oblative suicides** - sacrifice (self-immolation), transfiguration (belief in a higher order transformation)

4. **ludic suicides** - ordeal (take risk to prove oneself), game (Russian Roulette)

D. **Understanding the suicidal risk is essential in treatment. Key issues in assessing the risk of suicide are:**

1. **elevated agitation** - the decision to kill oneself takes energy

2. **constriction** - has the person given up - this is a critical question since suicide necessitates a very reduced tunnel vision

3. **lethality of the intent, method, plan** - this is difficult to assess with adolescents - the therapist must look at the covert signs - does the client have a specific method she or he is thinking of.

E. **Identifying the primary source of the unendurable pain allows for treatment** (Shneidman, 1985). What is the problem the client is trying to solve? Encourage the client to share the sources of the despair, such as: sadness, depression, helplessness, murderous hate. Help the client express her/his rage and frustration.

F. **Treatment of suicidal patterns**

1. **For the client's protection,** the therapist must evaluate the client, medicate, if necessary (or obtain a medication evaluation) and possibly hospitalize.

2. **Contracting for safety is not sufficient as an intervention.** Contracting must be used as an assessment tool, to help evaluate the risk.

3. **Short-term cognitive-behavioral therapy** (Beck, et al, 1979)

   a. identify the depressogenic thought, ex: helplessness, hopelessness
   b. distancing, de-centering - look at the distortions
   c. re-structuring - building viable substitute thoughts
   d. homework assignments

4. **A holistic or team approach** is recommended including the psychotherapist (using short-term cognitive-behavioral therapy and later psychodynamic therapy dealing with long-term issues of loss), psychiatrist (for medication needs), family therapist, environmental social worker (if the client has been hospitalized)

5. **Long-term psychodynamic treatment** allows the therapist to:

   a. provide active engagement and empathic responsiveness;
   b. uncover suicidal fantasy material; use confrontation strategically; manage countertransference
   c. resolve recent and early life losses (from Barent Walsh, DSW, workshop, Lynn, Ma., Dec. 1993).

G. **It is the responsibility of the therapist** to recognize the possibility of suicide, or determine if the client is competent to assume responsibility for her or his own actions, to discuss the possibility of suicide with the client and to discuss alternatives with the client (Gilliland and James, 1993).

H. **Legal Issues**

The therapist must be aware that there may be legal issues which result from what she or he does with regard to a potential suicidal client, therefore it is essential to keep good client notes. Client notes should contain (1) what you did, (2) why you did it, (3) why you chose not to do something else, (4) whom you contacted for confirmation of your decision - preferably someone at a higher level than you, i.e.: supervisor.

COUNSELING SPECIFIC POPULATIONS

Counseling particular populations necessitates particular expertise and awareness on the part of the therapist. Additional training and experience may be necessary. At the very least, the therapist must be aware of particular problems of that population and believe there is hope that the person can feel better and experience life differently than their present state of discontent.

1. Counseling elderly populations

A. **In counseling elderly clients,** it is important to remember that aging affects the entire person, in physical, spiritual, and economical ways, as well as the social, psychological and even the political realms.

B. **Therapists working with the elderly need to respect and care about elderly persons.**

They need to have had positive experiences with elderly people, and need the ability and desire to learn from elderly people. The therapist needs to be patient, to understand the biological aspects of aging and believe that the last years of one's life have worth and value. The therapist needs to know the special needs of elderly clients biologically, psychologically and socially and to be sensitive to the difficulties and anxieties of getting old. The therapist needs to question the myths about old age and to encourage elderly clients to do so as well. He/she must have a healthy attitude toward their own eventual aging (Corey & Corey, 1971).

C. **Therapists need to be aware of, and have dealt with (at least to some degree), their own feelings about death and be familiar with the psychological responses to death** of denial, anger, bargaining, depression, acceptance (Kubler-Ross, 1969). (Responses to death are explicated further in the section on Developmental Psychology.)

D. **In seeking treatment, the elderly client is often looking for a sense of meaning in her/his life.** Elderly persons often come to treatment because of the many changes and/or loss they are experiencing, such as a decrease in physical abilities, changes in their social life and social role, changes in their relationships and life status. The therapist needs to support the client's feelings and help her/him cope with the current difficulties. In helping the client create a new identity or sense of self, the therapist needs to set specific treatment goals in conjunction with the client.

E. Special Issues:

1. **Sexual interest** continues into the 70's, 80's and beyond. However, it may be difficult for women to find a socially approved sexual partner, while men may experience temporary interruptions due to sexual dysfunction (because of depression or anxiety, unrelated to age).

2. **The losses that elderly people experience** can result in depression. Treatment includes developing limited objectives for treatment, determining the current problem, helping the client express her/his feelings, helping the client employ past successful problem-solving methods to the current problems. Brief sessions may be scheduled and repetition can be expected. Delving into early family issues is not generally helpful with elderly clients. In extreme circumstances crisis intervention and/or medication may be needed (Charatan, 1985).

3. **Suicidality:** There is a higher rate of suicide among the elderly and is rising for elderly males. The higher suicide rate is often due to bereavement and lack of social support. The client may need a referral for a medication consultation and in a few cases institutionalization.

2. Minority group clients

A. Awareness of Diversity:

1. In counseling minority clients, the therapist needs to be aware of the cultural, ethnic, and class diversities. It is helpful to acknowledge to the client the therapist's awareness of differences. It is also helpful to ask the client if she/he has any concern regarding these differences.

2. Showing respect for differences and appreciating the strengths of different cultures and socioeconomic groups are important attributes the therapist needs to develop. It is important not to generalize about all clients belonging to a particular race, culture, or class. It is most important to focus on understanding the particular client with whom one is working.

B. Effects of Prejudice and Need for Validation:

The therapist should not refer to negative stereotypes. It is helpful for the therapist to be aware of social and community supports to which to refer the client. It is important that the therapist recognize the real problems that exist for minority or lower socioeconomic groups. Discrimination and prejudice are real in social, economic and political areas and need to be validated, while helping the client to recognize and use her/his personal strengths. The therapist must recognize that suspiciousness and mistrust may be a legitimate response to past experience and may not reflect paranoia or defensiveness.

3. Clients with physical disabilities

A. Issues:

In working with clients with physical disabilities, the therapist needs to be aware of the phases of adaptation to traumatic disability and loss. These are: shock, anxiety, denial, depression, internalized anger, externalized hostility, acknowledgment, and finally, adjustment.

B. Therapeutic Approach:

The choice of specific therapeutic approaches depends on the client's needs, the degree of psychosocial impact, the onset, nature, course, and progression of disability, the client's support system and the counselor's knowledge and mastery of different intervention strategies. Person-Centered and Gestalt Therapy are particularly useful in the early phases of the adaptation process because they focus on the affect and are nondirective interventions. More effective in the latter phases of the adaptation process are the cognitive-behavioral and active-directive therapies such as: Rational-Emotive Therapy, Cognitive Therapy, Reality Therapy and Behavioral Therapy (Livneh & Sherwood, 1991).

4. Lesbian and gay clients

A. **Society's attitudes toward gay people and the resulting discrimination are felt throughout a gay person's life,** including their relationships and interactions with family, friends, lovers, and persons in the workplace. The gay lifestyle is seldom recognized, in the heterosexual world, as an acceptable alternative to the heterosexual lifestyle. There are few places where a gay person can find reinforcement or affirmation.

B. **Special Issues:**

1. **Absence of role models:** There are few realistic role models, for gay persons because of the need to keep sexual preference hidden. This is especially difficult for gay teenagers. There are no models for gay people to follow in their closest relationships as there are for heterosexual people, such as wife, mother, husband, father or lover. It is difficult for gay people to know how to go about being gay as nongays know how to be heterosexual. Because of society's attitudes and few, if any, role models, many gays are "heterosexual" in public, but are "more themselves" with other gays.

2. **Identity:** One of the greatest difficulties for gays is relating to people who don't know they are gay and to whom they don't want to reveal their sexual preference, such as at work, with family and with close friends. The need to be "closeted" creates great pressure on the gay person and may cause great anxiety.

3. **Homophobia among therapists** continues to exist. Homophobia refers to the fears and the negative attitudes toward gays and refers to persons who dislike and are afraid of gay people or gayness. It is related to society and culture and is not related to actual characteristics of gay persons. People who are homophobic may believe that homosexuality is a symptom of "incomplete development" and see homosexuality as a disorder. This attitude will reflect in the treatment with the gay client. DSM-IV does not consider (nor have two previous DSM's considered) homosexuality to be a mental illness. A homophobic therapist, regardless of his/her own sexual orientation cannot effectively treat gay clients and should refer those clients elsewhere.

C. **Treatment:**

1. Treatment of gay clients is the same as for nongay clients. If the therapist fears a sexual approach by a gay client, it is handled in the same way as fears of being approached by nongay clients. The therapist must be aware of how gay and nongay lifestyles differ and may lack practical knowledge regarding homosexuality and the homosexual lifestyle. The therapist may need to ask about the lifestyle of the gay client and be open to hearing the answer.

2. Recognizing and validating the gay person's experience in the world is important. Helping the client deal with oppression and prejudice may involve working with the lesbian or gay man on new coping skills. It may be helpful to work on assessing the reality of fear-producing situations. The client may need help accessing resources. Addressing a substance or alcohol abuse problem and helping the client deal with it may be necessary.

D. Multiple Oppressions:

1. Minority gay clients face racial and ethnic issues which are also important in considering their sexual orientation. They may come to therapy with additional suspicions and may expect the therapist to have prejudice based on both race and sexual orientation.

4. Gender issues

A. Sexism in therapy also continues to exist.

1. Therapists attitudes

The therapist must recognize her/his own sex stereotypes and prejudices and guard against the negative impact of sexism on their work. Sexism by therapists is less than it used to be, but still needs to be reduced and still has a profound effect on the counseling process. Both female and male therapists hold sexist views and mental health counselors must be aware of their own sexist attitudes (Bowman, 1982).

2. Effects of sexism on counseling

a. **Gender bias** is seen to a greater extent with female than male clients. Females have often been assessed on the basis of the stereotypical "healthy female" as defined in the Broverman et. al. (1970) studies as dependent, emotional, passive, and non-competitive. When the female client fails to meet that definition, she is more likely to be given a "sexist diagnosis".

b. Therapists may assess clients differently depending on gender. Judgments of the "healthy adult male" have been different from judgments of the "healthy adult female". Anger (for instance) may not be seen as part of the stereotype of the "normal" female and may be seen as an unhealthy characteristic in women. Many "angry" women have been seen as hysterical, thus being misdiagnosed, overmedicated and historically have been inappropriately institutionalized.

There may be a bias against female clients if the client is too active outside the home. The "family values" emphasis in society encourages women to focus more on home and family and less on activities (particularly work) outside the home. This may be viewed as a major problem for a female client who is seen as not achieving "normal femininity", thus necessitating more in-depth therapy. However, even a greater amount of activity outside the home in male clients may be seen as an interpersonal or relationship problem requiring less intensive treatment.

c. **Self-esteem**

Mental health workers must be aware of the damage to women's self-esteem when they are encouraged to meet only the needs of others at the expense of their own needs.

B. Feminist therapy

Feminist therapy grew out of the women's movement and consciousness-raising groups. In individual therapy, it emphasizes sociocultural implications of the client's role as a woman or man. These issues are viewed in light of women's and men's roles in society, supporting the client's life experiences and helping the client focus on personal power.

CHAPTER 9

Substance Abuse

HISTORY IN U.S.

Substance abuse has been with us since the Puritans. It seems the early settlers believed the drinking water was hazardous to their health and chose to quench their thirst with hard cider. In the late 1700's the city of New York sported almost 400 taverns, which provided one for every twelve adult males. (Gamwell and Tomes, 1995) Our modern culture provides many more substances to be abused than the Puritan society could have ever imagined. Today's clinician must be familiar with the many forms of substance abuse. Substances such as marijuana, cocaine, amphetamine and heroin, hold separate subcategories in the DSM-IV. It is essential that the clinician to be familiar with the six fundamental "pattern" matrices of the following categories:

- Dependence
- Tolerance
- Persistence
- Abuse
- Intoxication
- Withdrawal

DEFINITIONS

Dependence and abuse are defined across all substances. Intoxication and withdrawal are substance specific.

1. Substance dependence

A maladaptive pattern, leading to clinically significant impairment or distress with at least three of the following occurring in the same 12-month period:

- Tolerance
- Withdrawal (substance specific)
- Increased use over a longer period than was intended
- Persistent desire for a substance
- Unsuccessful efforts to cut down
- Spending a great deal of time obtaining or recovering from substance abuse
- Reduction or abandonment of social, occupational or recreational activities
- Continued use despite awareness of recurrent physical or psychological problems

2. Tolerance

Need for greater amounts to achieve similar results or diminishing effect with use of the same amount. **Reverse Tolerance** - the need for lesser amounts to achieve similar results.

3. Persistence

Unintended use of larger amounts or for longer than intended:

- Inability to control use, or persistent desire for the substance
- High time cost to obtain, use, or recover from the substance
- Giving up of important life activities because of use
- Continued use in the face of use-related psychological or physical problems

4. Substance abuse

Presumes no prior diagnosis of dependence and does require impairment or distress from a maladaptive pattern within a 12-month period. The diagnosis must contain one of the following maladaptive patterns:

- Failure in a major life role, obligation in some recurrent pattern
- Hazardous status such as driving while drunk
- Recurrent consequent legal problems
- Persistant use despite use-related socio-interpersonal problems

5. Substance intoxication (substance specific)

- Development of a reversible substance-specific syndrome due to the recent use of a substance
- Clinically significant maladaptive behavior or psychological changes due to the substance
- Symptoms not due to a general medical condition or other mental disorder

6. Substance withdrawal (substance specific)

- Development of a substance-specific syndrome due to the cessation or reduction of substance
- Clinically significant distress or impairment in social, occupational or other areas of functioning
- Symptoms not due to medical or other mental disorder

DIAGNOSIS

Clinicians should always screen for substance abuse by looking for danger signs such as problems in the marriage, on the job or other organic or role deterioration. Often reports from significant others in the client's life can help clarify substance use.

1. Dependence syndrome

A. Scale

1. **Mild dependence** - Having few symptoms in excess of those required for diagnosis
2. **Moderate** - between mild and severe dependence
3. **Severe** - Having many symptoms including:
    - a. Persistent desire or one or more efforts to cut down or control use
    - b. Spending a great deal of time acquiring, using, or recovering from substance use
    - c. Continued use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or increased by the use of the substance

B. Symptoms (within the scale)

1. Tolerance

2. Withdrawal symptoms after discontinuation of use or abstinence

3. Taking the substance in larger amounts or over longer periods than originally intended.

2. Assessment

A. Identify dependence syndrome and substance use disorders

B. Gather patient history. May include information from significant others

C. Physical Exam

D. Laboratory Examinations

- ◆ Urine/Blood
- ◆ Liver enzymes
- ◆ Serology
- ◆ HIV

E. Mental Status Exam

F. Assessment of other non-organic psychiatric disorders

G. General Testing

- ◆ MMPI 2
- ◆ 16 PF

DIFFERENTIAL DIAGNOSIS

In the DSM-IV, substance-related disorders are distinguished from non pathological substance use, such as social drinking and from the use of medications (prescribed or over the counter) for medical purposes, by the presence of tolerance, withdrawal, compulsive use, or related problems such as medical complications, role disruption, financial and legal problems.

Substance-Induced Mental Disorders are included in the general category for the particular disorder, i.e., Mood Disorders and Anxiety Disorders.

DUAL DIAGNOSIS

Dual diagnosis is a generic term that refers to patients who fit the criteria for some kind of substance abuse and other DSM diagnostic categories. These clients are often severely and chronically ill. Generally acute symptoms of substance abuse must be addressed, and use under control, before significant work can be done on other clinical problems. Once this is done, both or all problems can be actively treated. Treatment plans need to be monitored and eventually integrated for long term work and relapse prevention.

STAGES OF SUBSTANCE ABUSE

1. Preabuse stage

Increased susceptibility from genetic, personality, family, sociocultural and psychiatric risk factors

2. Experimental stage

The decision is made to try a substance confined to social situations with others supplying the substance

3. Early regular use

- A seeking for the altered states. Increased situational or solitary use
- The range of substances may increase
- Behavioral signs may appear

4. Late regular use

- Daily activities are planned around opportunities to use substances
- Withdrawal when not using
- Questionable control over use
- Frequency increases
- Unpleasant feeling states may worsen leading to more substance use
- Self-destructive and risk-taking behaviors increase

5. End Stage

- Constant dysphoria leading to increased use
- Drug use constant
- Substance selection less selective aimed toward availability

TREATMENT

1. Goals of treatment (Galanter and Kleber, 1994)

- Maximize motivation for abstinence
- Rebuild a substance-free lifestyle
- Maximize multiple aspects of life functioning
- Optimize medical functioning
- Identify and treat psychiatric symptoms and disorders
- Deal with marital and family issues
- Enrich job functioning and financial management
- Address spiritual issues
- Deal with homelessness
- Prevent relapse

2. Stages of treatment

Most clinicians are aware of the massive denial at work in substance abuse. A model offered by Prochaska (1992) that tracks the change process is:

A. Pre-Contemplation

The individual avoids confrontation of true issues and denies consequences.

B. Contemplation

There is at least some acknowledgment of personal responsibility and problems with a minimal willingness to change though none has begun.

C. Preparation

The decision point. There is enough willingness to acknowledge problem behaviors and their consequences and a willingness to initiate change.

D. Action

New behaviors are established to support positive coping and there is an avoidance of situations that support the substance abuse.

E. Maintenance

The individuals efforts are directed toward developing skills and patterns that avoid relapse and creating a positive lifestyle.

3. Treatment alternatives

A. Aversive conditioning, i.e., Antibuse

B. Relaxation training i.e., Yoga

C. Systematic desensitization

D. During inpatient detoxification a token program can be used to help the individual organize his/her behavior toward a more substance free lifestyle

E. Adlerian approaches appear to have the most support in the psychoanalytic approach with an emphasis on personal responsibility for their behavior

F. Cognitive and existential therapies indicated later in treatment

G. "Quit contract" - a contract with the clinician to quit is recommended - The contract explains the specifics about changes in behavior and lifestyle

H. Family therapy has also been found to greatly support change.

4. Treatment settings

A. Inpatient

B. Outpatient

C. Residential

5. Treatment modalities

A. Individual Psychotherapy

B. Family Therapy

C. Group Therapy

D. Recreational Therapy

6. Treatment research outcomes (Galanter and Kleber, 1995)

A. No Evidence of Effectiveness - this may be due to lack of data.

1. Anti-anxiety medications

2. Cognitive therapy

3. Confrontational interventions

4. Psycho-education
5. Electrical aversion therapies
6. General counseling
7. Group therapies
8. Insight-oriented psychotherapy
9. Nausea aversion therapies
10. Residential milieu therapies

B. Insufficient Evidence of Effectiveness (possibly due to lack of data)

1. AA Alcoholics Anonymous
2. Halfway houses
3. Acupuncture
4. Calcium carbimide

C. Indeterminate Evidence of Effectiveness

1. Non-behavioral marital therapy (Behavioral marital therapy - emphasizes the improvement of communication and problem solving skills)
2. Hypnosis
3. Lithium

D. Fair Evidence of Effectiveness

1. Antidepressant medications
2. Behavior contracting
3. Covert sensitization - uses the patients own imagination to develop aversive consequences
4. Oral and implant disulfiram (Antibuse)

E. Good Evidence of Effectiveness

1. Brief Interventions

FRAMES
Feedback regarding drinking
Responsibility placed regarding drinking

Advice to change
Menu of interventions and options for change
Empathic style of counseling
Self-efficacy emphasized

2. **Community Reinforcement Approach (CRA)**

   Ranking the patient's substance related problems and choosing strategies from a menu of alternatives designed to address problems

3. **Self control training:** Teaching a set of self-management skills

   a. Goal setting
   b. Self-monitoring
   c. Self-reinforcement
   d. Alternative coping skills

4. **Social Skills Training:** Learning how to form and maintain interpersonal relationships

   a. Communication skills
   b. Listening skills
   c. Problem solving skills
   d. Assertiveness skills

5. **Stress Management Skills**

   a. Relaxation strategies
   b. Systematic desensitization
   c. Cognitive strategies

F. Additional factors

1. Therapist characteristics

   a. High empathy
   b. Non aggressive confrontation

2. Setting

3. Matching patients to treatments

   a. Treatment is consistent with cognitive style

4. Using a broad-spectrum approach

5. The higher the abuse related problem the more intense the treatment and visa versa

6. Allowing the patient to choose his/her treatment approach

SPECIFIC SUBSTANCES

1. Alcohol

The term alcoholism was coined 137 years ago by Magnus Huss. Since then there have been many "enlightened" approaches to treatment. (Herster and Miller, 1989) Alcohol intoxication is a toxic condition of the body. Alcohol is absorbed through the stomach and intestine and oxidized in the liver with a maximum processing of one ounce of 100 proof alcohol per hour. The excess then affects the brain causing "intoxication." The process appears to be slower in females. The alcohol acts as a depressant that inhibits the higher brain centers first and then affects the lower brain. With increased toxicity there is a loss of more complex cognitive and perceptual abilities and eventually loss in simple memory and motor coordination. Long term abuse results in CNS dysfunction with problems exacerbated by vitamin deficiencies, poor diet, the breakdown of social and support systems, and the physical effects of the alcohol.

A. Initial Diagnosis

1. Direct Questions

Diagnosis in the DSM-IV includes many alternatives. The clinician will need to screen their client carefully to make an accurate diagnosis. Direct questions during the initial interview can include: (Zimmerman, 1994)

- How much do you drink now?
- Have you ever drunk too much? If yes - When?
- Has anyone ever told you that you drink too much?
- Has your drinking ever caused you problems in life? If yes - What kinds of problems?

2. Further Questions

If there is the potential for an alcohol abuse diagnosis, further questioning must be done to identify:

a. Alcohol Abuse - Due to your drinking how often do you:
  - Miss work?
  - Have trouble at school?
  - Not care for your children?

b. Alcohol Dependence
  - Do you need to drink more now to get high?
  - Have you noticed any of these problems when you try to quit or cut down?
    Shaking
    Can't sleep
    Anxious feelings

3. Intoxication Identifiers:

a. Slurred speech
b. Lack of coordination

c. Unsteady gait
d. Impairment in attention or memory
e. Stupor or coma
f. Autonomic hyperactivity
g. Sweating
h. Hand tremor
i. Insomnia
j. Nausea
k. Vomiting
l. Transient hallucinations or illusions
m. Psychomotor agitation
n. Anxiety
o. Grand mal seizures

3. **Alcohol Screening Tools:**

a. Alcohol Use Inventory (AUI)
b. CAGE self-report questionnaire:
    - Have they ever attempted to Cut back on alcohol?
    - Have there been Annoying comments made about their drinking?
    - Do they ever feel Guilty about drinking?
    - Do they need an Eye-opener in the morning to steady their nerves?
c. Chemical Dependency Adolescent Assessment Project scales (CDAAP)
d. Comprehensive Drinker Profile (CDP)
e. Essential-Reactive Alcoholism interview (ERA)
f. MacAndrew Scale (MAC)
g. Michigan Alcoholism Screen Test (MAST)
h. Substance Use Disorder Diagnostic Schedule (SUDDS)

4. **Pretreatment Evaluation Tools:**

a. Locus of Control (LOC)
b. Minnesota Multiphasic Personality Inventory (MMPI)
c. Rorschach
d. Sensation Seeking Scale Form V (SSC)
e. Sixteen Personality Factors Questionnaire (16PF)
f. Tennessee Self Concept Scale (TSCS)
g. WAIS-R

B. Treatment

Alcoholics are generally considered to overuse defense mechanisms to avoid dealing with their problems. Some believe they are part of the characterological structure of the alcoholic. In any case, breaking through the defense systems of the individual and getting them to admit there is a problem they need to deal with is the first step of beginning treatment. Listed below are the stages of treatment starting with getting the alcohol out of the system of the client.

1. **Detoxification** ideally at least three weeks in duration.

a. Inpatient or outpatient

2. **Chemotherapy**
   - a. Benzodiazepenes (anti-anxiety) for weaning the person away from alcohol
   - b. Methadone and imipramine (antidepressant) - for alcoholics where depression is a feature.
3. **Aversives**
   - a. Disulfiram
   - b. Calcium Carbimide (Temposil)
4. **Anxiolytics (anti-anxiety)**
5. **Neuroleptics (anti-psychotics)**
6. **Vitamins**
   - a. Thiamine
   - b. Multivitamin
7. **Psychotherapy -** The first task is to break through the denial
8. **Aversion therapy -** Administering electric shock during intoxication or playing a videotape of the person taken when they were drunk.
9. **Supportive therapy -** Social network of support such as Alcoholics Anonymous or Moderation Management.
10. **Nine to fifteen months are needed to adjust to an alcohol-free lifestyle.** A relapse-resistant lifestyle is considered to be in place within two to three years. The ability to remain substance free and have fun and enjoy life is considered a state-learned behavior. It is important for the clinician to help the recovered client to learn new skills with which to enjoy life.

2. Amphetamine use disorder

Tolerance to amphetamines builds quickly which leads to increased intake and dependence. Continued use over a significant period of time leads to paranoid ideation and psychotic symptoms that may persist after the substance is no longer in use.

A. Diagnosis

One of the first determinations that must be made is whether the substance is a prescription or street purchased drug.

1. **Interview questions that might be asked are: (Zimmerman, 1994)**
   - a. Have you ever used prescription medication for sleeping, weight loss, to kill pain or to calm you down?
   - b. If yes:
     - ◆ How long have you taken the drug?
     - ◆ Did you ever take more than was prescribed?

c. If no:
  - Have you ever used any drugs you got from friends or bought on the street?

d. If yes:
  - What did you get?

e. How frequently do you use it?
  - If the frequency is more than 10 times in life ask:
    Do you think you use drugs too often?
    Has anyone close to you said you use them too much?

f. Have the drugs ever caused problems for you?
  If, yes:
  - What kinds of problems?
  - How old were when you started having these problems?

1. Testing

a. MMPI-2
b. 16 PF
c. MCMI-III

B. Treatment

1. **Existential Techniques -** Since underlying problems such as anhedonia or depression are present existential techniques to confront apathy and cognitive behavior techniques are useful.

2. **Behavioral Techniques** such as covert sensitization which is a sub category of covert conditioning is also helpful.

C. Other Issues to be Addressed

1. The presence of an eating disorder or obesity must also be addressed.

2. The presence of Attention Deficit Disorder must also be addressed.

3. Caffeine-related disorders

Most caffeine use can be attributed to the use of coffee, soda, over the counter medications, stimulants, weight-loss aids, and chocolate. The symptoms are clinically significant when they interfere with or impair social, occupational or other roles of functioning, and are not due to medical condition or other mental disorders.

A. Diagnosis

When diagnosing the clinician must consider if the caffeine is the cause of or exacerbating other problems such as anxiety disorders or sleep disorders. Caffeine induced disorders are considered clinically significant when five or more the following signs develop during or after the ingestion of at least 250 mg. of caffeine:

- Restlessness
- Nervousness
- Excitement
- Insomnia
- Flushed face
- Diuresis
- Gastrointestinal disturbance
- Muscle twitching
- Rambling flow of thought and speech
- Tachycardia or cardiac arrhythmia
- Periods of inexhaustibility
- Psychomotor agitation

B. Treatment

Education about the occurrence of caffeine in the daily diet can help the patient reduce their intake. Behavioral interventions much like the ones used with smoking cessation can be used.

4. Cannabis

Use appears to be on a continuum of occasional or experimental to compulsive daily abuse. Marijuana is often the first illicit drug used by the young after use of alcohol and cigarettes. There is a lot of social interaction in early use and it is used for relaxation as it progresses to weekly or daily use. Finally the goal might be to remain "stoned" all day long. It is often used to alter the effects of other drugs, to reduce the anxiety created by cocaine use and amplify alcohol intoxication. Marijuana is believed to be the most frequently used illegal psychoactive drug in America.

A. Diagnosis

1. The clinician needs to:

a. Evaluate the past and current use of cannabis as well as other drugs.
b. Identify past problematic behaviors.
c. Try to correlate problem behaviors to drug use.

2. The same kinds of questions that were used to assess street drug use can be asked:

a. How frequently do you use it? If the frequency is more than 10 times in their life ask:
  - Do you think you use drugs too often?
  - Has anyone close to you said you use them too much?
  - Have the drugs ever caused problems for you?

b. If drugs have caused a problem:
  - What kinds of problems?
  - How old were when you started having these problems?

3. The determination needs to be made whether the use is dependence or abuse.

4. Other assessments that need to be made are:

a. Physical exam
b. Urine analysis
c. Mental status
d. Non-organic psychiatric symptomatology
e. Family interview

B. Treatment

1. Intoxication

a. Panic attacks
b. Anxiety reactions
- ◆ Calm reassurance in a supportive atmosphere "talking down."
- ◆ Psychopharm - A fast acting anxiolytic such as Diazepam.

2. Psychosis

a. Close observation in a warm supportive environment and continued reassurance that these thoughts and feelings will go away and are caused by the drug.
b. Psychopharm - same as above possibly in higher doses Neuroleptics - Haldol

3. Delirium

a. Treatment is symptomatic to the delirium.
Psychopharm:
Anxiolytics
Neuroleptics

4. Flashback Syndrome

a. Reassurance
b. Anxiety relief
c. Anxiolytics

5. Recovery - Early phase is from 1-12 months. Relapse signs are:

a. Euphoric recall
b. Remembering only the positive aspects of the drug experience
c. Reentering the social situations where use occurred

6. Psychotherapy

a. It is often difficult to establish a therapeutic relationship with abusers.
b. Positive transference should be encouraged in the early stages of treatment. Client dependency should be accepted.
c. Therapist needs to have a good understanding of the cultural language and pharmacological end effects of the drug.
d. Enhance interpersonal functioning.
e. Reduce anxiety.
f. Recognize maladaptive behaviors.

7. Family Therapy

a. Improve communication patterns.
b. Address parental expectations.
c. Address parental or sibling drug use.

8. Group Therapy

a. Teaches socialization skills.
b. Teaches problem solving skills.
c. Reduces sense of isolation.
d. Offers a support system for abstinence.
e. Helps to identify maladaptive behaviors.

9. 12-Step Programs

10. Behavioral Therapy

a. Relaxation exercises.
b. Assertiveness training.
c. New coping skills.
d. Contracting.

5. Cocaine abuse

Cocaine has been used for centuries by important figures in the culture such as Freud, Sherlock Holmes (created by Arthur Conan Doyle) and John Philip Sousa. Cocoa leaves were chewed by the Aztecs and millions of southern American Indians. Many Americans were unknowingly habituated to it in the 1800's by drinking Coca-Cola advertised as a "brain medicine." Short-term use of cocaine inhibits the reuptake of dopamine leading to an increased concentration and transmission of dopamine causing euphoria. Long-term use depletes the brain of dopamine, norepinephrine and serotonin. Mixed with alcohol a new substance called cocaethylene forms in the liver amplifying its effects and increasing the risk of heart attack 20 times.

A. Diagnosis

This client also needs to be assessed for dependence or abuse of cocaine as well as the potential for dual diagnosis. Personality changes appearing as narcissism, a competitive attitude and a super achievement-oriented personality with a strong fear of intimacy and vulnerability. This can lead to diagnostic considerations such as:

1. Narcissistic Personality Disorder

2. Obsessive-Compulsive Personality Disorder

B. Testing

MMPI-2
16 PF
MCMI-III

C. Treatment

1. **Inpatient detoxifying** which can last from a few days to three months.

2. **The extinction phase** can last from three to twelve months.

3. **Chemotherapy**

   a. Calcium channel blockers reverse the effects of toxicity.
   b. Buprenorphine
   c. During withdrawal
      - Bogaine
      - Desipramine

4. **Psychotherapy**

   a. Confrontation techniques.
   b. Helping the addict to take more control over their decisions.
   c. Planning adaptive behaviors to satisfy needs.
   d. Resolution of spiritual and intimacy-betrayal and avoidance issues.
   e. Treatment for underlying depression.
   f. Anonymous programs.

   The critical skills appear to the ability to learn, apply and live through relapse crisis.

6. Hallucinogen-related disorders

Includes Ergot and related compounds such as LSD, morning glory seeds, mescaline, MDMA, Ecstasy, Psilocybin, DMT and other related compounds. It does not include PCP and Cannabis. Effects are varied depending on the drug of choice and amount consumed. Perceptual alterations are noticed with changes in:

- Color
- Geometric patterns
- Distorted forms

  These changes can take place with the eyes open or closed
- Greater sensitivity to touch, and sometimes taste and smell
- Synthesis - overflow from one sense modality to another
- Subjective time is altered
- Hyper-suggestibility and distractibility
- Changes in ego functioning
- Chronic use can create personality change.

A. Diagnosis

Is often made from the individuals self-report. Clinical diagnosis is often made when the individual is actively hallucinating, delusional or describing any of the above changes.

Laboratory tests to be done:

1. Blood

2. Urine

B. Treatment

1. General

a. Individual experiences range from pleasant to frightening which are commonly referred to as "bummers" or "bad trips."
b. Acute anxiety or panic reactions usually wear off before intervention is necessary.
c. Reassurance and support, or talkdown, is done in a quiet, pleasant environment in a homelike setting. The patient should sit up or walk around being reminded that extraordinary thoughts and feelings are a result of the drug and will soon disappear.

2. Chronic Adverse Reactions

a. Symptoms resembling personality disorders have been noted as well as psychotic reactions.
b. When reactions are life threatening inpatient treatment is recommended.

3. Flashbacks

a. Long term psychotherapy.

4. Psychopharmacology

a. Anti-psychotics are sometimes helpful for extreme anxiety but paradoxical reactions have been reported.

7. Inhalant-related disorders

Includes mental disorders brought on by the inhalation of aliphatic and aromatic hydrocarbons found in gasoline, glue, paint thinners, and spray paints. Less common substances are halogenated hydrocarbons found in cleaners, typewriter correction fluid, spray can propellants and other volatile compounds containing esters, ketones, and glycols. Most of the above are inhaled and can produce psychoactive effects and can be extremely life threatening. It is often difficult to identify the exact substance creating the problem. They may all be used interchangeably depending on availability and preference. There are subtle differences in the actions and effects but not enough is known about the differing effects to distinguish them. They can all produce dependence, abuse, and intoxication.

A. Methods of Ingestion:

1. Fabric soaked in the substance held over the nose and inhaled.

2. Vapors released into a bag and then inhaled.

3. Vapors inhaled directly from aerosols or sprayed directly into the mouth or nose.

4. All of the above reach the bloodstream quickly and create intoxication.

B. Diagnosis

1. May present with auditory, visual or tactile hallucinations or other perceptual disturbances. Delusions may have developed during periods of intoxication. Anxiety may be present. Substance abuse may begin with school problems and/or family conflict. Most often inhalants are used by adolescents in a group setting.

2. Dependence has been identified in industrial workers with long-term occupational exposure to inhalants. Use may also occur when substance abusing individuals find themselves in prison, the military, in residential situations, isolated in rural areas and do not have access to their drug of choice.

C. Treatment

No particular treatment methodology has been identified at this time. Treating the general dependency syndrome is advised. If the client is a child, the family should be included in treatment if it does not pose a threat to the child's safety.

8. Nicotine dependence

Nicotine, a highly used substance in tobacco form in America is also used as an effective pesticide. Nicotine is considered to lead to dependence but not to abuse. There appear to be seven major factors crucial in starting and maintaining a tobacco addiction:

- Modeling and ease of access
- Peer pressure
- Physiologic addiction
- Genetic predisposition
- Habit and ritual
- Paradoxical tranquilizing effect of nicotine on the chronic smoker
- Personality needs such as oral eroticism

A. Diagnosis

Very often the nicotine dependent client is self referred, or referred by a physician due to chronic physical ailments. It is also noted that a history of major depression is common in heavy smokers.

B. Treatment

1. Treatment efforts have had limited success and when successful the relapse rate is very high.

2. Support of those around the smoker seems to help.

3. Gradual titrating of the nicotine itself like using nicotine gun or patches helps some.

4. Prevention is more effective than cure.

5. Psychotherapy

   a. The following strategies delivered during therapy seem to help:
      - Increasing delay strategies.
      - Identifying a "quit day."
      - Use of nicotine gum.
      - Hypnosis, autogenic training and/or relaxation training used to develop coping skills.
      - Aversive techniques such as rapid smoking techniques.
      - Attention to diet and exercise.
      - Treatment of any other disorders such as depression or anxiety disorders.
      - Support group.

- Family therapy to facilitate support and eliminate subversive behaviors.
- Behavioral training to cope with stress and avoid high-risk situations.

6. Success in quitting proceeds as follows:

   a. Consideration of change
   b. Crystallization - realistic expectancies about the annoyances that may arise when they quit.
   c. Concrete preparation
      - Learning anti-stress skills such as hypnosis and yoga
      - Contracts with others
   d. "Just do it" phase:
      - Smoking is cessated and new behaviors put in place
      - Coping strategies are used to deal with withdrawal
      - Continues for three to six months
      - Often there is weight gain.
   e. Maintenance - lifestyle changes put in place.
   f. Anti-Relapse - a plan is made ahead of time to avoid behaviors that may lead to relapse.

9. Opioid use disorder

The Opium poppy has been used for at least six thousand years. Abuse increased with the invent of morphine and heroin which creates a warm, sensual euphoria. Tolerance develops rapidly and withdrawal is often within six to twelve hours after a heroin injection. The 1980's saw the rise of cocaine use, the 1990's appears to be the decade of heroine.

A. Diagnosis

The primary distinguishers are opioid dependence, active intoxication or withdrawal. While intoxicated the client may experience sexual dysfunction, suffer hallucinations or delusions and experience sleep disorders. These clients are not usually self referred but are often received via the criminal justice system, the school system, or as a result of other medical complications or a pregnancy.

1. **Initial Information.** It is important to identify:

   - How frequently and for how long the drug has been used.
   - The day and time of last use.
   - Route and amount.
   - How much it cost.
   - Why it is being used i.e., to get high or relieve other problems.
   - Any previous treatment.
   - Prescriptions drugs being concurrently used.
   - Medical problems.
   - Social situations.
   - Living arrangements.
   - Sexual orientation.
   - Employment.
   - Family relationships.
   - Use of leisure time.

2. Physical Examination

It is important to get a complete physical workup to rule out any organic contributors to the problem. Basic tests to be obtained are:

- Urine
- Blood
- Chest x-ray
- HIV test
- Hepatitis
- Electrocardiogram (40+ years)
- Pregnancy test
- Tuberculin skin test

B. Testing

1. Addiction Severity Index
2. MMPI-2
3. 16 PF
4. WAIS-R

C. Treatment

The highest success appears to include long-term therapy, methadone maintenance and active involvement in a support group. Therapeutic communities have been useful but are often difficult to access. The first step in treatment is detoxification. The ideal, but not the average, detox time frame is 3-6 months.

1. **Detoxification Period** - During the detoxification period the following substances can be used to ease the withdrawal:

   a. Methadone
   b. Naolxone

2. **Withdrawal Period** - After the withdrawal phase the client needs to look toward longer treatment of the underlying problems that led to the addiction. Chemical interventions during this phase can include:

   a. Tranquilizers
   b. Antidepressants

10. Phencyclidine use disorders

The Phencyclidine substances include PCP, Semylan and similarly acting substances such as Ketamine or Ketalar, Ketaject and TEP. They are usually obtained as street drugs and can be taken orally, intravenously or can be smoked. Common street names are PCP, Hog, Tranq, Angel Dust, and Peace Pill. It is believed that withdrawal occurs but it is difficult to identify since it is a very subjective experience.

A. Diagnosis

1. Behavioral Assessment and Physical Examination

Diagnosis is based on behavioral assessment of the changes that take place after ingestion of the substance. Physical perceptions may include horizontal and/or vertical mystagmus, hypertension, tachycardia, diminished pain sensation, ataxia, dysarthria (stammering), muscle rigidity, seizures, and hyperacusis (sound sensitivity). A physical examination should include:
- Blood Screen
- Urine Screen

2. The clinical interview should include:
   - History of use.
   - History of complaints from friends or family members.

B. Treatment

Initial treatment includes protective supervision in a non stimulating environment to protect from self-injury.

1. Belongings should be searched to rule out further substance resources.

2. Vital signs should be monitored.

3. Restraints avoided.

4. Talking-down techniques are helpful during acute hallucinations but should be avoided afterwards because they may intensify agitation.

11. Sedative, hypnotic, or anxiolytic use disorders

Sedatives and hypnotics are commonly prescribed to reduce anxiety and treat insomnia. Benzodiazepenes are commonly known as Xanax, Librium, Klonopin, Tranxene, Valium, ProSom, Mazicon, Dalmane, Paxipam, Ativan, Versed, Serax, Centrax, Doral, Restoril and Halcion. Most people who are not anxious don't find their effects pleasurable. Individuals who become dependent on Benzodiazepenes can be classified into one of three groups:
- Street drug-abusers.
- Alcoholic individuals who are given prescriptions for other problems.
- Patients with depression or panic disorders who are prescribed high-doses for long periods of time.

A. Diagnosis

The clinical interview should identify the source of the drug, street or prescription. Then the distinction of dependence or abuse must be determined. Symptoms such as mood disorders, anxiety disorders, sexual dysfunction and sleep disorders need to be sorted out from the effects of the drug. "Clients who have been diagnosed with depression or panic disorders may have been prescribed high doses of Benzodiazepenes for long periods of time by their treating physician. This does not necessarily equate with a substance disorder or contraindicate benzodiazepine treatment" (Galanter and Kleber, 1994).

B. The Dependence/Withdrawal Cycle

1. This occurs often during long-term treatment of:

a. Generalized anxiety disorder
b. Panic disorder
c. Severe insomnia

2. Process

a. Pre treatment phase - The time before the patient was treated with benzodiazepines.

b. Therapeutic response phase - Side effects such as:
   - Drowsiness
   - Psychomotor impairment
   - Memory impairment may occur.

c. Tolerance develops within a few days and may last within the range of days to years.

   - **Symptom escape/dosage escalation phase** - the chosen benzodiazepine may suddenly lose its effectiveness. It may coincide with increased life stress or not. Dosage may be increased or drug substitution made. Those with the above interventions are at greater risk for protracted withdrawal symptoms.

   - **Withdrawal phase** - when the daily dose falls below 25% of peak maintenance and the patient becomes increasingly symptomatic. There may even be an emergence of new symptoms.

   - **Resolution phase** - following symptom rebound and a period of abstinence lasting months to over a year. Symptoms will vary in intensity from day to day. Those who can remain drug free for over 5 weeks show lower levels of anxiety than before discontinuation.

12. Polysubstance abuse

A. Diagnosis

1. Identification

a. When a person has used at least three different substances (not including caffeine or nicotine) for at least six months and no substance has reached dominance.
b. There is often a seeking for solutions to problems outside of self or a seeking for external stimulation.
c. Polysubstance abusers often appear to be more deeply disturbed than other monosubstance identified individuals.
d. Often late adolescence or young adults.

2. Testing

- MMPI-2
- 16 PF
- MCMI-III

B. Treatment

1. **Detoxification** can include acute withdrawal reactions. The standard stabilization sequence requires:

    a. The use of oxygen to stabilize respiration
    b. Inderal for any cardiac arrhythmia's
    c. A barbiturate to reduce CNS stimulation
    d. Benzodiazepines to control convulsive reactions.
    e. These responses are short-term and need to be carefully monitored to avoid secondary abuse behaviors like solicitation of more drugs from peers to ameliorate the withdrawal symptoms.

2. **Psychotherapy**

    a. Group treatment that emphasizes confrontation
    b. Rational-emotive or reality therapy

3. **Family therapy**

C. Treatment

1. **Withdrawal**

    a. The clinical picture is often similar to withdrawal from barbiturates and might include:
        - Anxiety
        - Tremors
        - Nightmares
        - Insomnia
        - Anorexia
        - Nausea
        - Vomiting
        - Postural hypotension
        - Seizures
        - Delirium
        - Hyperpyrexia (increased body temperature)

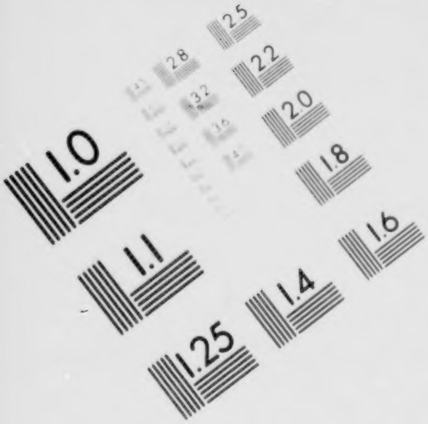
    b. The course of treatment depends on the drug of abuse.

2. **Symptom rebound**

    There may be symptom rebound when the drug is removed or an intensified return of the symptoms the drug was prescribed for. Rebound lasts a few days to weeks.

3. **Protracted withdrawal** from benzodiazepines

    a. Symptoms consist of relatively mild symptoms such as:
        - Irritability
        - Anxiety
        - Insomnia
        - Mood instability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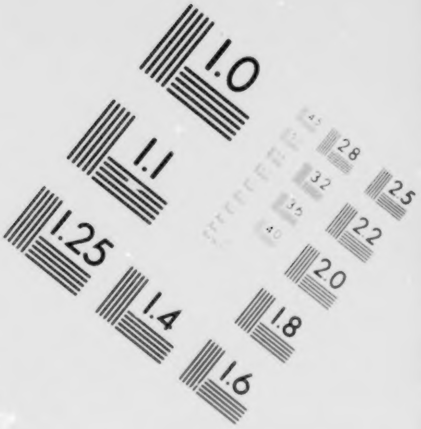
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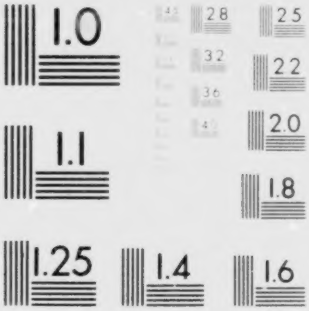
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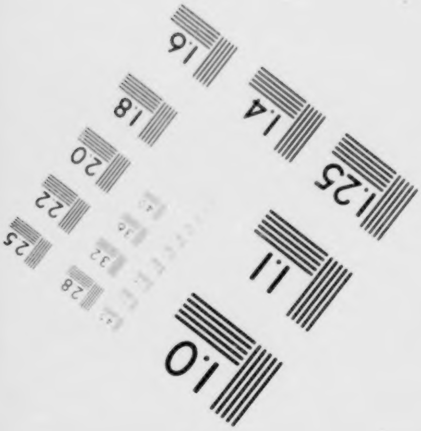
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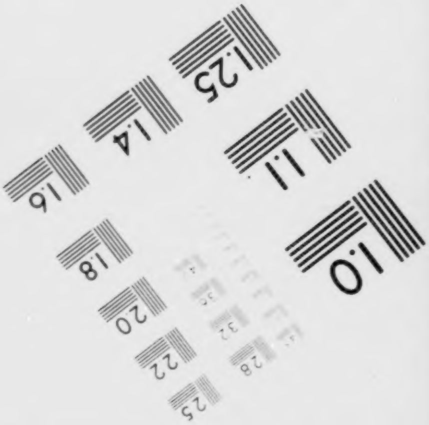
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b. These symptoms can be severe and disabling and last many months. Some have described the process as mimicking an obsessive-compulsive disorder with psychotic features. Other symptoms might include:
   - Increased sensitivity to sound
   - Light
   - Touch
   - Paresthesias

4. **Recrudescence -** Symptom reemergence differs from symptom rebound in that it implies that the original symptoms have not been adequately treated.

13. Other substance-related disorders

Includes the use of Anabolic Steroids, Nitrite inhalants, Nitrous oxide and the abuse of prescription drugs.

A. Prescription Drug Abuse

Rather than differentiate between the substances the method of obtaining the substance is addressed. The trend has been away from the barbiturates of the past which were abused to amphetamines and minor tranquilizers that are heavily abused currently. The abuse tends to emerge in individuals between the ages of 30 and 60 in middle-class and upper-class females. They generally consume prescribed tranquilizers for nervous complaints or insomnia and gradually increase the dosage often layering an increase in the use of alcohol. The abuse is often not detected since 90% of the substances are prescribed by physicians who have no special training in psychological disorders. Common signs of abuse are:

- Efforts toward making sure prescriptions are filled quickly.
- Developing backup prescriptions or physician contacts.
- Resistance-avoidance toward any health care professional who begins to confront the pattern.
- Increased contacts with sympathetic health care workers.
- Depression and anxiety increase when prescription refills are delayed or renewals are threatened.
- Withdrawal from standard interests, friends or activities.
- Increased use of alcohol to supplement the pill's effects.

B. Treatment

1. Since a high percentage of the abusers have a middle-class value system hospitalization for detoxification is well accepted. The initial stage includes tension and depression. Relaxation training is helpful. Helping the individual identify areas in their lives in which they have control increases self-efficacy.

2. Assertiveness training.

3. Expansion of social networks and exacerbating problems such as insomnia and obesity also need to be addressed in treatment.

CHAPTER 10

Psychopharmacology

Psychopharmacology is an area of knowledge that is important to today's counselor. Drugs have helped relieve the use of hospital beds previously occupied by the chronically mentally ill. We still only partly understand why drugs work, and the research and use continues. The counselor's consideration of psychopharmacological intervention needs to come from an informed perspective rather than an across the board belief that drugs are good or bad. The things you need to consider with medication are:

To what extent is this problem due to psychological factors and to what extent is it due to a biochemical disturbance? (Preston and Johnson, 1992)

In the service of this question the first intervention is a current physical exam or a contract with the client to have one. After this question has been answered the next questions to consider follow.

What do you do when you take in a new client who is currently on medication?

It is important you understand how prescription medication and street drugs affect your client. It would be a good idea to obtain the name of the prescribing physician/s and obtain releases to verify the type and dose of each medication the client is taking. Then, you need to do your homework so you understand each medication.

What do you do when you believe a client might benefit from medication?

You need to discuss the possibility with your client from an informed perspective. There are several diagnosis that have treatment protocols that include the possibility of psychopharmacology.

They include:
- Schizophrenia
- Depression
- Bi-polar
- Anxiety
- Attention Deficit Disorder

Then, if the client agrees, direct him/her to consult with his/her current physician for medication or a referral to a psychopharm specialist. If the client does not have a physician it is important you have a physician you can refer to who is knowledgeable in the areas of psychopharmacology.

What do you need to know about medication?

You need only be familiar with the general categories of drugs used in treatment. In order to understand a drug it is recommended you understand:

- Type of drug
- Indications - when it may be helpful
- Action or Course
- Tolerance
- Dependency
- Side Effects
- Precautions
- Withdrawal

Remember, when you see your client ask yourself the following:

- Is this client currently on medication?
- What do I know about the medication and its effects?
- Have I obtained a release so I can obtain further information from their physician?
- Could this client benefit from psychopharmacological intervention?
- Has this client been advised of this resource?
- If the client is on or chooses to use psychopharm, what information do I need to inform them of?

IMPORTANT CONCEPTS

1. Action

Pharmacokinetics

Psychoactive drugs interact with the Central Nervous System (CNS) and produce changes in mood, consciousness, perception and often times, behavior. In order to affect users, psychoactive drugs need to be in a sufficient dosage to create an effect. This concentration can be determined by how much is taken, as well as how the drug is "distributed." This distribution process is referred to as the drug's "pharmacokinetics" which includes:

- Absorption
- Distribution
- Transformation by metabolism
- Excretion

Pharmacodynamics

The term "pharmacodynamics" refers to the process involved in how the drug begins its effects at its particular action site in the CNS, i.e., neurotransmitter substances such as norepinephrine, serotonin or dopamine.

2. Drug tolerance

Tolerance is a reduced response to a drug as the result of repetitive use. The body becomes increasingly effective at eliminating the drug or the receptor cells become less sensitive to the drug because of repeated exposure. This drives the need for an increase in dosage to maintain the same objective or subjective experience.

Marked Tolerance
Substance abuse occurs when the maladaptive behavior pattern caused by substance use does not meet the criteria for a diagnosis of "Substance Dependence" but does involve continued use of the drug despite knowledge of its negative impact on social, occupational, psychological, or physical conditions and/or recurrent use of the drug in physically hazardous situations.

3. Dependence or addiction

A compulsive need to use a drug to experience its effects or avoid the discomfort that occurs when the drug is reduced or eliminated.

A. Physical

Physical dependence can result from a drug tolerance reaction. Biochemical changes occur in the body.

B. Psychological

A powerful drive to experience the effects of the drug such as euphoria, an altered state of consciousness, or a reduction in anxiety. For more detail refer to the chapter on Substance Abuse.

4. Precautions

A. Synergism

Individual drug effects can be changed with the addition of other substances such as other drugs, foods or hormones. Some substances will increase a drugs effect while others will reduce the drugs effect. The term "synergistic" refers to the increase of the effect of a substance combination such as alcohol and other sedative or hypnotic drugs.

B. Withdrawal

The dynamics of withdrawal are drug specific. It does not necessarily follow that it is easier to withdraw from a psychological addiction than a physical addiction.

PSYCHIATRIC DRUGS

In the following categories of drugs you will find specific drugs listed. They are examples and not necessarily a comprehensive list in each area.

1. Antipsychotics major tranquilizers and neuroleptics

Psychosis is not an illness it is a symptom indicating impaired reality testing. Research supports the theory that antipsychotics work by blocking dopamine receptors in the brain. Since schizophrenia is thought to be related to overactivity of dopamine receptors it is one of the syndromes treated with antipsychotics. Other diagnosis often treated with antipsychotics are:

- Psychotic mood disorders
- Mania and depression
- Psychosis associated with neurological conditions such as Alzheimers and head injuries.

These agents reduce or eliminate delusions and hallucinations, reduces affective tension and psychomotor agitation, augment activity and restore contact with reality. There are many ways a client can have impaired reality testing or loss of contact with reality such as:

- Confusion
- Delusions
- Hallucinations
- Impairment in judgment and reasoning

When psychosis is present it is generally a good idea to make a referral for psychiatric consultation.

A. Types

Phenothiazines
    Thorazine - Chlorpromazine
    Mellaril - Thioridazine
    Stelazine - Trifluoperazone
    Serentil - Mesoridazine
    Prolixin - Fluphenazine

Thioxanthenes
    Navane - Thiothixene

Butyrophenones
    Haldol - Haloperidol

Dibenzazepine
    Loxitane - Loxapine
    Clozapine - Clozaril (blood needs to be drawn weekly)
    Zaproxyl

Dihydroindolone
    Moban - Molindone

B. Indications

Anorexia
Agitation
Assaultive behavior
Blunted affect
Bizarre thinking
Catatonic behavior
Confusion
Delusional thinking
Depression
Disorientation
Hallucinations
Insomnia
Mania
Memory loss
Paranoid thinking
Psychomotor agitation
Social withdrawal
Thought withdrawal

C. Course

These drugs are usually effective in two stages:

First stage
The patient is sedated but remains afflicted with psychotic symptoms

Second stage
The patient loses their delusional and hallucinatory symptoms and can go to a lower maintenance dose

D. Dependency

Anti-psychotics are thought to not be addictive or become tolerated either psychologically or physically.

E. Side Effects

1. **Anticholinergic** (autonomic)

Dry mouth
Blurred vision
Tachycardia
Urinary retention
Constipation

Appear early and tolerance ordinarily develops within a few weeks or months. Elderly patients are most susceptible.

2. Orthostatic Hypotension

- Abnormally low blood pressure when standing
- Tolerance usually within the first several weeks of drug use
- Sedation

Can be tolerable if client is agitated or aggressive. Tolerance usually develops within several days or weeks.

3. Extrapyramidal Effects

- Akathasia - a sense of inner restlessness.
- Motor restlessness
- Dystonia - lack of muscle tone
- Muscle spasms in mouth, face and neck
- Parkinsonism - tremor, face expressionless, speech slow, muscular rigidity, head bowed, small quick shuffling steps
- Tardive dyskinesia - most serious. Symptoms are often irreversible unless recognized early and treatment is stopped. Involuntary rhythmic movements of the jaw, lips, tongue and extremities.

4. Other

- Jaundice
- Blood dyscrasias
- Skin rashes
- Higher sun sensitivity, may burn more easily
- Amenorrhea
- Infertility
- Impotence
- Increased appetite and weight gain
- Insomnia
- Depression
- Lowered seizure threshold

F. Precautions

These drugs can cross the placental barrier and produce birth defects or side effects in the newborn. A 30-60 day supply of antipsychotics taken all at once can be fatal when consumed with a CNS depressant.

G. Symptoms

- Hypotension, dizziness
- Severe urinary retention
- Seizures
- Sore throat during first several months of treatment
- All of the above sometimes referred to as "neuroleptic malignancy."

H. Withdrawal

- Abrupt withdrawal may cause:
- Insomnia
- Nightmares
- Sleep disturbances
- Cholinergic rebound such as abdominal cramps, diarrhea, increased salivation

2. Minor tranquilizers or anti-anxiety agents - anxiolytics

First introduced in the 1950's as an alternative to barbiturates for relieving anxiety, they are effective in treating anxiety, tension and psychosomatic disorders. They have also been used to control alcoholism, epilepsy, and phobic states. When you are considering the diagnosis of anxiety the following questions need to be answered before making the referral for a psychopharm assessment:

- Is this a generalized anxiety disorder?
- Is this anxiety stress related?
- Is this a panic disorder?
- Is this a social phobia?
- Is a medical illness present with anxiety symptoms?
- Are the anxiety symptoms part of a primary mental disorder such as depression or schizophrenia?
- Is the anxiety being caused by some other substance?

A. Types

1. Propanedios

Miltown/Equanil - Meprobamate

2. Benzodiazepines

Valium - Diazepam
Librium - Chlordiazepoxide
Xanax - Alprazolam
Serax - Oxazepam
Dalmane - Flurazepam
Ativan - Lorazepam

3. Non-Benzodiazepine

BuSpar - Buspirone

4. Beta-Blockers

Inderal - Propanolol

5. Anti-convulsants

Tegretol
Klonopin - Clonazepam

B. Clinical Indications

Used for exogenous (outer) anticipatory anxiety, but not if the endogenous (inner) anxiety from panic attacks is the sole factor.

GAD - Generalized Anxiety Disorder
Panic Disorder
Phobic Disorders
OCD - Obsessive-Compulsive Disorder
PTSD - Post Traumatic Stress Disorder
Tobacco abuse
Depression
Withdrawal
Headache
Chills nausea
Vomiting
Anxiety
Irritability
Motor Restlessness

C. Action

These drugs mediate the actions of GABA, the brain's major inhibitory neurotransmitter. They are most effective on a time-limited basis since they have been found to produce similar adverse side effects, withdrawal symptoms and patterns of abuse similar to the barbiturates. Actions arise in 15-40 minutes and effects can be determined after 1-2 doses.

D. Dependence

The relaxation, euphoria and sense of well-being promotes psychological dependence. Chronic use can create physical tolerance and dependency.

E. Side effects

Drowsiness
Lethargy
Ataxia (loss of muscle coordination)

F. Precautions

These drugs should not be consumed with other CNS depressants. Excessive coffee use can counteract the effects.

G. Withdrawal

Anxiety
Agitation
Insomnia
Anorexia
Muscle cramping
Tinnitus

Blurred vision
Headaches
Hypotension
Hypothermia
Psychosis
Seizures

3. Antidepressants - used to relieve depression

When you have considered the diagnosis of depression it is important to distinguish between:
- Reactive sadness
- Grief
- Medical illness and any medication that may be causing depressive symptoms
- Clinical depression (Preston and Johnson, 1992)

If the clinical determination is clinical depression psychopharmacological interventions may be appropriate if the symptoms have been sustained.

A. Types

Antidepressants are divided into three types:

1. Tricyclic (TCA)
2. Tetracyclic (HCA)
3. Monoamine-Oxidase Inhibitors (MAOIs)

B. Indications

Major depression
Chronic pain
Anorexia nervosa
Bulimia
Pseudodementia
Agoraphobia
Attention deficit hyperactivity disorder
Atypical depression
Borderline personality disorder
Dysthymic disorder
OBD
Schizoaffective disorders
Treatment resistant depression

C. Action

TCA's usually require 10-14 days to start working, full effect in apx. 6 weeks

D. Dependency

Not thought to create dependency.

E. Side Effects

Anticholinergic (interferes with the action of acetylcholine in the brain)
Blurred Vision
Dry Mouth
Sweating
Constipation
Urinary Retention
Orthostatic Hypotension
Tachycardia
Palpitations
Hypertension
Confusion
Skin rashes
Paresthesias (feels like bugs are crawling on the body)
Blood Dyscrasias
Nausea
Vomiting
Weight gain
Changes in libido
Paradoxical agitation or depression
Lowered seizure threshold
Insomnia
Disorientation
Sedation

F. Precautions

When starting, clients should be careful driving cars, working around machines, and crossing streets, since reflexes may be off.

Ataxia
Drowsiness
Delirium
Cardiac arhythmia's
Seizures
Coma

G. Withdrawal

Suddenly stopping TCA's can trigger nausea, bad dreams, altered heart beat, and cold in 2-4 days. For withdrawal, dosage should be titrated off.

H. Types Expanded

1. Tricyclics TCA

Sinequan - Doxepin
Tofranil - Imipramine

Elavil - Amitriptyline
Desipramine - Norpramin

Most often used for the treatment of depression. Elevate mood and increase overall activity, increase appetite and improve sleep patterns. Good for endogenous depression rather than an exogenous or reactive depression. Since they take 2-4 weeks to take effect ECT is sometimes recommended for clients with severe depression who are a high suicide risk.

2. Tetracyclics

Thought to be more effective than the Tricyclics they are similar in terms of their therapeutic action and side effects.

- Monocyclic
- Bicyclic

Thought to have fewer side effects than any of the other drugs. Often identified as Selective Serotonin Receptacle Inhibitors (SSRIs):

Prozac - Fluoxetine
Paxil - Paroxetine
Zoloft - Sertraline

3. MAO Inhibitors

Most effective for treating atypical depression. The MAO's create their effects by inhibiting the enzyme monoamine oxidase which is involved in the deactivation of epinephrine, norepinephrine, serotonin, and a number of other neurotransmitters and body chemicals. Serious hypertensive crisis can occur when taken in conjunction with barbiturates.

Nardil - Phenelzine
Parnate - Tranylcypromine

4. Mood stabilizers

A. Types: Lithium

B. Indications

Lithium is the drug of choice for the treatment of mania. It is also used for:

- Bipolar disorder
- Unipolar depression
- Schizoaffective episodes
- Emotionally unstable character disorder
- Borderline
- Premenstrual dysphoria
- Alcoholism

C. Action

Its therapeutic effects often do not occur until 7 to 10 days after the first dose.

D. Dependence - is not found to create dependence.

E. Side Effects

Muscle Weakness
Tremors Of The Hand
Fatigue
Nausea
Vomiting
Diarrhea
Weight Gain
Polydipsia
Precautions
Coarse Tremor
Severe Lethargy
Slurred Speech
Ataxia
Confusion
Convulsions
Coma

F. Precautions

Lithium affects the renal system and needs to be closely watched with blood testing to obtain an optimal dosage that does not begin to degrade the renal function.

5. Sedatives-hypnotics

A. Types

Benzodiazepines
Barbiturates
Barbiturate like hypnotics
Non-Benzodiazepines

B. Indications

Cataplexy (sudden loss of postural tone)
Narcolepsy (sudden sleep)
Night terrors
Sleep apnea
Sleepwalking

C. Action

Generally act as CNS depressants and are dose dependent. Low dose - reduces arousal and motor activity. Large dose - induces sedation and sleep.

D. Dependence

Chronic use results in tolerance, psychological dependence and physical dependence.

E. Precautions

A small amount of alcohol with a modest dose of barbiturates can have lethal consequences.

F. Withdrawal

Abrupt withdrawal causes:
Tremors
Anxiety
Nausea
Vomiting
Paranoia
Hallucinations
Delirium
Life threatening convulsive seizures

1. Barbiturates

Introduced in the early 1900's for sleep and relaxation their use has been expanded and their addiction potential identified.

A. Types

Amytal - Amobarbital
Nembutal - Pentobarbital
Seconal - Secobarbital
Luminal - Phenobarbital

B. Indications

Insomnia

C. Dependency

High likelihood of tolerance, psychological dependence and physical dependence.

D. Side effects

Slurred speech
Dizziness
Irritability
Impaired motor movement
Cross the placental barrier and can produce birth defects or congenital dependency
Can cause a decrease in REM sleep and nightmares

E. Precautions

Are an abused class of drugs for:

1. Middle and upper class individuals who obtain prescriptions for insomnia or anxiety.
2. Adolescents who obtain the drug illegally and use it for recreation.
3. Abusers of amphetamines, cocaine, alcohol and other drugs who use barbiturates to counteract the negative effects of those drugs.

F. Dangers

Barbiturates are frequently involved in suicide and accidental death when mixed with alcohol or other drugs. Since the respiratory centers do not adapt to the drugs effects and other systems might, the user might not know when they are taking a lethal dose.

G. Overdose Symptoms

Ataxia
Confusion
Agitation
Disorientation
Cold/clammy skin
Dilated pupils
Respiratory depression
Death

H. Withdrawal

Generally severe and can be life-threatening. Recommend 10% dose reduction at a time.

6. Ethyl alcohol

Once widely used medicinally as an analgesic, anesthetic and tranquilizer, its medical use has virtually ceased due to the development of more effective drugs.

Alcohol is the most frequently self-administered and widely abused legal drug in our culture.

7. Opioid-analgesics

A. Types

1. **Natural** - Derived from the opium poppy the natural opioids are:

   Opium
   Morphine
   Codeine

2. **Semisynthetic** derivatives of morphine

Heroin
Percodan
Dilaudid

3. **Pure synthetics**

Demerol
Darvon
Methadone

B. Indications

Medically the opioid-narcotics are used for the same reasons that opium was used centuries ago for the treatment of diarrhea, as a cough suppressant, and as an analgesic.

C. Action

Have both sedative and analgesic effects.

D. Dependency

Chronic use results in tolerance, psychological dependence and physical dependence.

E. Side Effects

Constricted pupils
Decreased visual acuity
Increased perspiration
Constipation
Nausea
Vomiting
Respiratory depression
Crosses the placental barrier and can cause congenital dependency

F. Precautions

Slow and shallow breathing
Muscle rigidity
Catalepsy
Clammy skin
Decreased blood pressure and pulse rate
Convulsions
Coma
Death from respiratory failure

G. Withdrawal

Stomach cramps
Nausea

Vomiting
Weakness
Fever
Muscle and joint pain
Sweating
Mild hypertension
Insomnia
Methadone is used for heroin withdrawal

8. CNS Central Nervous System Stimulants

Although abused illegally, stimulants can be used to treat:

ADHD Attention Deficit Hyperactivity Disorder
Treatment resistant depression
Narcolepsy
AIDS

TYPES

1. Amphetamines

Amphetamines exert their effects by stimulating the release of norepinephrine, dopamine, and serotonin in the brain. They are referred to as sympathomimetics because they mimic the actions of the sympathetic nervous system. Amphetamines decrease fatigue, enhance physical and mental performance, stimulate talkativeness, elevate mood, excite tremors, decrease appetite, dry the mouth, increase perspiration, dilate pupils, and create bruxism. Available in the 1930's as prescription drugs, they have been used to treat narcolepsy, depression, petit mal epilepsy, obesity, brain damage and hyperactivity in children.

A. Dependency

Not believed to result in physical dependence long-term use can result in tolerance and psychological dependence.

They are highly abused both in prescription form and on the street as methadrine or speed.

B. Side effects

Nausea
Vomiting
Irritability
Headache
Palpitations
Dizziness
Anxiety
Apprehension
Confusion
Dysphoria

C. Precautions

Prolonged use can cause psychosis and is characterized by hostility, aggression, hallucinations, delusions of persecution, cardiac arrhythmia's, diarrhea and abdominal cramps. Symptoms can become chronic.

2. Methylphenidate

Better known as Ritalin, is a derivative of amphetamine but less powerful. Used to treat epilepsy, obesity, depression and narcolepsy. Currently being used to treat attention deficit hyperactivity disorder.

A. Side effects

Anorexia
Insomnia

B. Dependency

Not believed to create dependency

3. Cocaine

Made from the leaves of the coca plant, cocaine is a potent local anesthetic and central nervous system stimulant. Effects include feelings of euphoria, excitation, restlessness, perceptions of increased strength and mental abilities. Freud used cocaine as a cure for heroine addiction.

A. Side effects

Dilated pupils
Tachycardia
Decreased appetite

B. Precautions

Can mirror amphetamine psychosis and paranoid schizophrenia
Hypervigilence
Agitation
Impaired judgment
Paranoia
Severe depression
Visual and tactile hallucinations
Serious overdose can cause convulsions, coma and death

C. Dependency

May lead to psychological dependence. May produce "reverse" tolerance.

D. Use

May be taken intra nasally (snorted) and can also be injected intravenously or smoked in a purified alkalinized form (free-basing). First experience is a "rush," when it is smoked or injected the effect is more immediate. The effect is short lived followed by dysphoria and a craving for more cocaine. Because of the craving, and cost of the drug, cocaine can create serious emotional, financial and social problems.

E. Withdrawal

Fatigue
Nausea
Hunger
Chills
Tremor
Severe depression

9. Hallucinogens and cannabis

A. Hallucinogens

Heighten sensory awareness, perceptual distortions, emotional lability and alterations in thinking.

1. LSD

Altered perceptions are the major experiences of LSD. The psychological effects depend on the dosage, purity as well as the personality and expectations of the user. There is also impact from the environment such as location and those one takes the drug with.

a. Precautions

Bad trip
Delirium
Depersonalization
Psychosis
Flashbacks

b. Dependency

Not thought to be physically or psychologically dependent.

c. Withdrawal

None

2. PCP - Angel Dust

Originally used as an animal tranquilizer and human anesthetic. No longer produced in the US, it still seems to be available. PCP is one of the most dangerous hallucinogens and is associated with assaultiveness, paranoia, psychomotor agitation, ataxia, muscle rigidity, nystagmus, slurred speech, vomiting, convulsions, respiration depression, hypertensive crisis, seizures, coma and death.

B. Cannabis

Archaeological data suggests that cannabis has been used for medical, religious and recreational purposes for at least 6,000 years.

Today it is sold illegally as marijuana and hashish. The psychoactive ingredient is THC tetrahydrocannabinoth. Usually smoked and can be eaten. Medically it is used to alleviate nausea and vomiting and for glaucoma, reducing intra ocular pressure.

The effects are dose dependent. Psychologically the effects usually include mild euphoria, relaxation, an altered sense of time, heightened sensory awareness, giddiness, food cravings, slowed thought processes, and impaired short-term memory and concentration. Physically it increases blood pressure and heart rate, dry mouth and lowers body temperature.

1. Dependence

Long term use can lead to psychological and physical dependence.

2. Side effects

a. Panic
b. Anxiety
c. Paranoia
d. Social withdrawal
e. Dysphoria
f. Depersonalization
g. Hallucinations
h. Flashbacks
i. Chronic use can create "amotivational syndrome" which is indicated by:
  - Apathy
  - Listlessness
  - Decreased attention span
  - Lower motivation
  - Poor judgment
  - May possibly decrease testosterone levels, sperm count, and cause birth defects.

3. Withdrawal

a. Restlessness
b. Irritability
c. Loss of sleep
d. Anorexia
e. Diarrhea
f. Weight loss
g. Hyperactivity tremor
h. Tremor

PROFESSIONAL/CLINICAL ISSUES

A. Clinical Assessment

When doing a clinical assessment for psychopharacology, always ask:

1. Is there a biological clinical component identified by the DSM-IV?
2. Has there been a history of drug use, legal or illegal?
3. Is there a potential for abuse or suicide?
4. Is the client outpatient or inpatient?
5. Does the medication need close monitoring?
6. How does the client feel about using medication?
7. Is there a biological component identified by treatment guidelines?

B. Treatment Planning

Treatment planning needs to be done with a knowledge of the effects of the medication and course of treatment. There should be an exchange of information between the prescribing physician and the treating therapist about any change in the client's condition.

C. Referral To Professionals

Have the client check with their current primary physician for treatment or referral. In the absence of a personal physician have a physician you have a working relationship with, to whom you can refer your clients'.

D. Patient Education

1. Clients should know their diagnosis unless there is a clinical reason this would be contraindicated.
2. The target symptoms and what the drug is supposed to reduce.
3. The length of time they will be on the drug.
4. Both expected and possible adverse effects.
5. The treatment plan to be followed if the drug is unsuccessful.

If you do not believe the client can comprehend this information, tell them anyway in as clear a way as possible. If they have a caretaker, with a release if needed, provide this information. Document this has been done.

CHAPTER 11

Research and Evaluation

RESEARCH DESIGN

Research is the empirical, systematic investigation of the relationship between two or more variables in a controlled way. The purpose of research is to conclude that variation in the dependent variable is caused by variation in the independent variable and to answer a question in a controlled, systematic format.

1. The research process

The research process begins with identifying the question to be studied as clearly as possible, and a tentative hypothesis established. The background of the problem is then considered and explored, including a review of the relevant literature. The variables are defined and a research strategy is selected. The study is then conducted, and the results are analyzed, conclusions are reached and the research findings are reported.

2. A research design

A research design is necessary for research to be systematic. The research design must be based on a plan specifying (1) a general research strategy, (2) designation of the population of interest, (3) the method to be used to select the sample from the population, (4) nature of the variables to be studied, (5) conditions under which the study will be conducted.

A. Variable

A variable is any aspect of a person, group, or setting that is measured for the purposes of the study in question. Variables are any phenomenon or characteristic capable of variation, or of existing in at least two different states, conditions, or levels.

1. Variables come in two forms: independent variables and dependent variables. Independent variables are believed to be the cause of change or variation in a dependent variable. Variation in dependent variables "depends on" variation in an independent variable. Independent variables are the characteristics or phenomena to be controlled while the dependent variables are the characteristics or phenomena to be tested for. Consider the following statements:

   a. What is the effect of (independent variable) on (dependent variable)?
   b. If . . . (independent variable), then . . . (dependent variable).

2. A continuous variable is a variable which is potentially able to take on any value within a continuous range of values, ex: age, height, temperature.

3. A discrete variable is a variable that can assume only certain values, ex: political party, DSM-IV categories, Beck Depression Scale.

B. Sampling

Sampling is the method used to select subjects from the population of interest (since often the entire population cannot be studied).

1. Simple Random Sampling: Before a sample will adequately serve as a basis for making estimates of population parameters, it must be representative of the population in all respects. Use of a Table of Random Numbers is the simplest method of drawing a random sample. It is a computer-generated list found at the back of most statistics books. Using this form of selecting a sample from a population, every member of the population has an equal probability of being selected for inclusion in the sample.

2. Stratified Random Sampling can also be used where the population is divided into appropriate strata (ex: gender, age, education level). Subjects are randomly selected from each stratum.

C. **An hypothesis** is a statement relating to the study that is to be proved or an idea that has been formulated so that it may be evaluated using scientific methods. It is an "educated guess" that states a predicted relationship between events or variables. It is generally stated: "If A exists, then B will occur."

D. **A research strategy** is the "plan of action". Conducting an experiment means systematically varying one or more conditions for some groups, but not for others.

E. **The study** is to be carried out objectively enough to permit others to replicate it. All steps in the research process must be specified.

F. **An analysis of the results** considers the likelihood that the findings are simply due to chance. The research results include making a distribution of the scores obtained by the subjects; calculating relevant descriptive statistics (describing certain aspects of the subject's performance, i.e., the mean or average); and calculating inferential statistics (used for judgments about the probability that the results are due to chance).

G. **Reporting the research findings** communicates ideas and findings to others and forces the researcher to think through all that has been done and the meaning attached to it. It is an important aspect of the research.

3. Two kinds of research are generally conducted:

A. **Applied research** is done in a naturalistic setting. This research is conducted to answer a certain question in which the investigator is interested and the results have immediate application.

B. **Basic research** is done in a rigorously controlled setting and is pursued without regard to the immediate applicability. This research focuses on theoretical rigor and control.

4. Several research strategies are possible

A. **Experimental research** is characterized by "experimental control". The investigator controls (manipulates or changes) certain independent variables and randomly assigns subjects to treatment groups. The investigator has tight control of the variables to make generalizations to other larger groups (populations) which are similar in important characteristics to the group being studied (sample). Experimental research is conducted to conclude that variation in a dependent variable is caused by variation in the independent variable. The hypothesis would state that variation in the dependent variable is caused by variation in the independent variable.

B. **In Quasi-Experimental research,** the researcher cannot control the levels of the independent variable and/or the assignment of subjects to treatment groups. With quasi-experimental research it is not possible to rigorously follow the experimental approach. The study is set up to resemble the experimental approach, recognizing that the results and the ability to generalize the findings are limited.

C. **Ex-Post Facto research** or "after the fact" research design is where the independent variable is not manipulated by the researcher because the change has already taken place. The experimental treatment is applied and/or the dependent variable data is collected prior to onset of the study. An Ex-Post Facto design cannot be classified as experimental research because no manipulation or control of the variables has taken place.

D. **The purpose of Descriptive research** is to describe "what is", what the existing state of affairs is in whatever area one is examining. No cause and effect explanations are inferred in descriptive research. It is often used as background material for more controlled investigations. Examples of descriptive research are: case studies, surveys, developmental research, correlational studies.

E. **Historical research** reconstructs and examines past events to arrive at conclusions. This kind of research is frequently done to show how previous experience may contribute to understanding of present or future circumstances. Historical research lacks control over manipulation and measurement of variables. There is little control over sampling and no possibility of replication.

5. There are several threats to the validity of a research study. Research can be subject to contamination through:

A. **Internal contaminators** including the personal rigidity of the researcher

B. **Internal/external contaminators** including social desirability, faulty definition, investigator influence or faulty interpretation

C. **External contaminators** such as sampling bias, inappropriate design and questionable instrumentation

6. Group research designs include:

A. One-Group Design

Administration of a single level of an independent variable to one group of Subjects (S's) - an example is a pre-test-post-test design. The researcher administers one form of an academic test to all children in one classroom. The teacher then introduces a 5-minute exercise period every hour during a six week period. The researcher then administers a second form of the same test. The researcher assesses the effects of the exercise period by comparing scores on the two forms of the academic test.

B. Two-Group Design

Administration of one level of an independent variable to one group of S's and another level to the other group. When one group receives some level of the independent variable, it is called the "experimental group"; when a group receives no treatment or a contrast treatment, it is called the "control group". For example, a researcher administers a pretest to the identified hyperactive children in the school. Half the hyperactive children are then given Ritalin (the experimental group) for a period of time while the other half do not receive any drug (the control group). Post-tests are then given to all the hyperactive children. The researcher assesses the effects of the Ritalin by comparing the posttest scores of both groups.

C. More Than Two-Group Design

One or two groups of S's are assessed on one or two levels of a single independent variable. The researcher in the one-group design example could expand the design by including three levels of the independent variable i.e., 1) exercise 5 minute period with no teacher involvement, 2) teacher-administered 5 minute exercise period, and 3) no exercise period. The researcher would randomly assign subjects to one of the three groups, administer a pretest to subjects in all groups, tell one group to watch the clock and on the hour to get up, go to the back of the room and exercise (quietly) for 5 minutes, tell the teacher to have her group go into the hall for 5 minutes for exercise and have the other group continue working. The post-test would then be administered and results assessed.

D. Repeated measures design

A dependent variable is administered to the same S's on more than one occasion, for example:

1. Each S receives one treatment but two or more administrations of the dependent variable, e.g., pre-test - post-test designs

2. Each S receives two or more treatments and two or more administrations of the dependent variable e.g.: a counterbalanced design where several groups each receive treatments (ex: different amount of exercise time) in a different order.

7. Single-subject research designs use repeated measures of the dependent variable throughout the baseline and treatment phases of the study.

A. AB Design

Compares S's status on the dependent variable during two phases. The researcher gives a test for anxiety several times during both Phase A (baseline - no treatment given) and Phase B (treatment given). Phase A and B are compared.

B. ABAB Design

AB design is expanded to include more than one baseline (Phase A) and treatment phase (Phase B).

C. Multiple Baseline Design

Does not require the withdrawal of treatment as ABAB design might. It involves sequential treatments given, with more than one baseline for each behavior with:

1. different behaviors of the same subject
2. the same S in different settings or conditions
3. the same behavior of different S's

CHAPTER 12

Statistics

TYPES OF STATISTICS

There are two types of statistics: Descriptive Statistics and Inferential Statistics. Descriptive statistics involves tabulating, depicting, and describing collections of data. It is a tool for describing, summarizing or reducing to comprehensible form the properties of an otherwise unwieldy mass of data. Inferential statistics predicts or estimates characteristics of a population from a knowledge of the characteristics of only a sample of the population. Statistical methods assist researchers in describing data, in drawing inferences to larger bodies of data, and in studying casual relationships. The choice of a particular method depends, in part, on the type of data collected and in part, on what information is needed from the data and to what use it will be put.

1. Descriptive statistics

Descriptive Statistics are used to describe an entire set of data or distribution of data or a single observation in that set of data. An entire set of data can be described in tables, graphs, measures of central tendency or measures of dispersion. An individual observation in a set of data can be described in relation to the entire set by converting the individual score into a type of transformed score such as a percentile, rank or z-score.

A. Scales of Measurement

When data is collected in research studies, it is quantified by using one of four scales of measurement: nominal, ordinal, interval or ratio. Each scale differs in the amount of information it provides and the type of mathematical operations which can be used with it. The level of measurement limits the applicability and interpretation of certain statistical measures and methods.

1. **The Nominal Scale** is considered the most primitive level of measurement. The categories are unordered, mutually exclusive and exhaustive and do not reflect differences in magnitude, merely distinguishes groups. Examples: sex, political affiliation; eye color; DSM-IV diagnosis.

2. **The Ordinal Scale** places observations into categories which provide information about ordering. The information is ranked from greatest to least and is used when data is categorized on the basis of rank order. It does not provide information about the magnitude of the intervals between categories, because the intervals cannot be assumed to be the same distance apart, for example: first, second, third; a questionnaire which asks for "agree", "disagree", or "strongly agree" with a statement; high/moderate/low. When data is categorized on the basis of rank order, 1st, 2nd, 3rd, an ordinal scale of measurement is being used.

3. **The Interval Scale** can equate the magnitude of intervals between successive points on a scale. It allows comparison statements to be made between individuals or things being measured. The zero point on the scale is arbitrary and does not correspond to total absence of the characteristic being measured. Examples of interval scales include: class grades; family income less than \$5,000, \$5,000 - \$9,999, \$10,000 - \$13,999, etc.

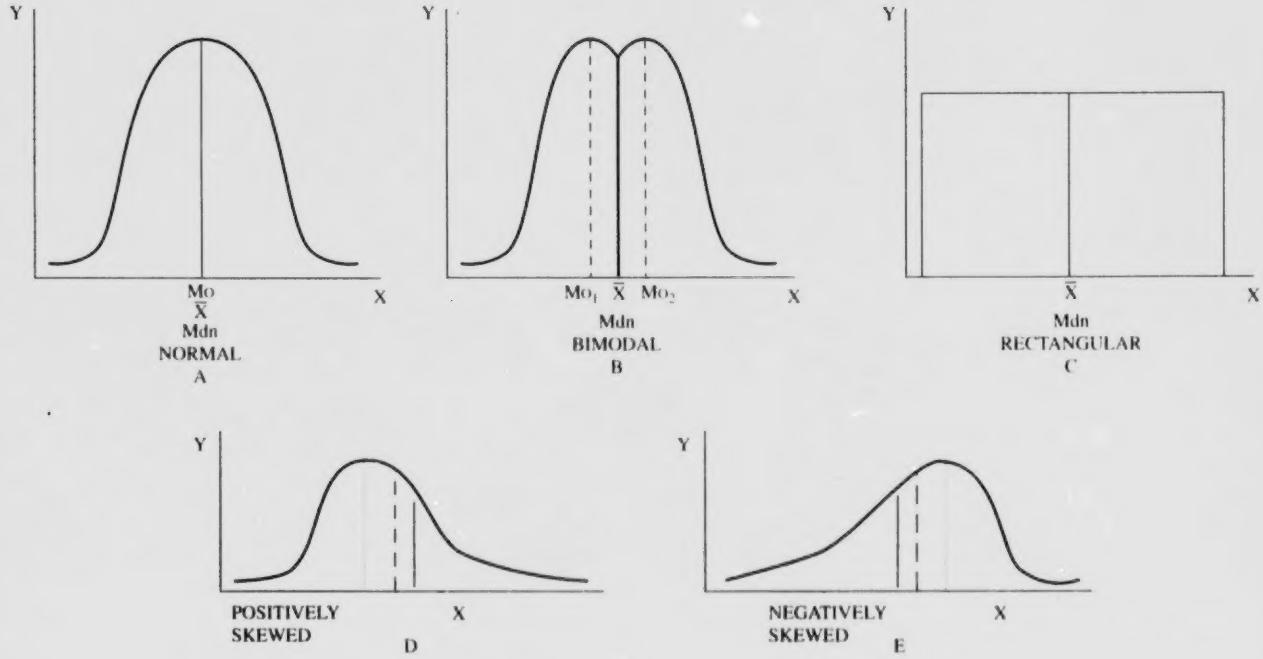
4. **The Ratio Scale** is identical to the interval scale but also has an absolute zero point. Zero indicates the complete absence of the trait or construct and the numbers represent equal units from absolute zero. Observations can be compared as ratios or percentages. The ratio scale can, for example, state if a person has two or three times as much of the trait being measured as another person. Examples are: height; weight; age; time; Kelvin (absolute temperature).

B. **Frequency Distributions** arrange and describe observations so that the pattern of their distribution is easily seen.

1. **In Tables,** the frequency of the distribution is constructed by summarizing data in terms of the number or frequency of observations in each category, score or score interval.

2. **In Graphs,** the data can be concisely summarized into bar graphs or histograms or into frequency polygons. Frequency polygons are constructed by joining the midpoints of the histogram bars.

3. **The Normal Curve.** When a sufficiently large number of observations are made, the data takes on the shape of a bell-shaped or normal curve (the data is "normally distributed"). The right half of the curve is the mirror image of the left half; the observations are approximately symmetrical (see A below). Distributions that have two distinctly different points around which scores cluster are called "bimodal" curves (see B below). In a rectangular distribution, the frequency of scores is constant across all values of X (see C below). Skewed or asymmetrical distributions are seen in D and E below. In D (positively skewed), there are a greater number of scores at the low end and "tail off" at the high or positive end. If a test is very difficult, the number of scores might be greater at the low end (students didn't do very well) and tail off toward the high end. E shows negative skewness where the high scores are clustered together on the high end and "tail off" toward the left, the low or negative end. If a test is very easy, many students may do well and scores would "bunch up" at the high end, tailing off toward the low end, indicating a negatively skewed distribution of scores.



Key: $\overline{X}$ = ________ Mo = ... Mdn = _ _ _ _
Mean Mode Median

C. Measures of Central Tendency

1. **The Mode** (Mo) is the score (or category) that occurs most often in a set of data. The data can have more than one mode. (Ex: 2, 3, 4, 4, 4, 6, 8, 9, 10, 11, 11 - the mode is 4)

2. **The Median** (Mdn) is the score that divides a set of data in half when the data has been ordered from lowest to highest. It is the middle score in a set of odd number of observations, or the value that lies midway between the two middle values in an even number of observations. The median is the 50th percentile of a distribution - the point below which half the observations fall. There will always be an equal number of cases above and below the median. In the example above, the median is 6 since an equal number of observations (5) fall above and below 6. If one score in a distribution of scores is extremely high or low, the value of the median will not be affected. The median is the second most used measure of central tendency.

3. **The Mean** (Arithmetic Mean) is the "balance point" of a set of scores. It is obtained by finding the sum of all the scores and dividing by the N (number of scores in the set of scores). Ex 1: In the above example, the $\overline{X} = 6.5$; $= 72 / 11$ (N) $= 6.5$ (M or $\overline{X}$). Ex 2: If 3 workers are 40, 45, and 65 years old, the Mean age is 50 yrs; $40 + 45 + 65 = 150 / 3 = 50$. The Mean is preferred whenever possible and is the only measure of central tendency that is used in advanced statistical calculations because:

   a. It is generally the most reliable or accurate of the three measures of central tendency. The Mean generally fluctuates less widely than either the Mode or the Median.

b. The Mean is better suited to further arithmetical computations, thus is the most used measure of central tendency.

M or $\bar{X}$ = arithmetic mean
Σ = "the sum of"
X = each of the measurements or scores in turn
N = total number of measurements or scores

c. The Mean is sensitive to extreme scores and so is often not the appropriate measure to use when a distribution is skewed.

In a normal distribution, the mode, median and mean are the same, but in skewed distributions, they are not the same. In positively skewed distributions, the mean is greater than the median, and the median is greater than the mode (see D above). In a negatively skewed distribution, it is reversed. The mode is greater than the median, and the median is greater than the mean (see E above). In skewed distributions the mean is "pulled" further toward the tail of the distribution than either the median or the mode and the median is "pulled" further than the mode. The mode is the greater number of scores in skewed or normal distributions.

D. Measures of Variability (Dispersion)

Measures of variability or dispersion indicate how the distribution of scores spreads out from the center. The two most important statistical characteristics of any distribution of observations are its central tendency and its variability. Examples of measures of variability (dispersion) are:

1. **Range:** the simplest measure of variability, calculated by subtracting the lowest score from the highest score. Used only for ordinal, interval or ratio scales since the data must be ordered.

2. **Variance:** indicates the extent to which individual scores in a distribution of scores differ from one another.

3. **Standard Deviation:** is the square root of the variance. The standard deviation is the most widely used measure to describe the dispersion among a set of observations in a distribution. It is often used in computing other statistics.

E. Characteristics of the Normal Curve

The normal curve is symmetric about its mean. The half of the distribution to the right of the mean is the mirror image of the left half; the skewness of the distribution is zero. In a normal distribution, approximately 68% of all scores fall between one standard deviation above and one standard deviation below the mean, approximately 95% of all scores fall between two standard deviations above and below the mean, and approximately 99% of all scores fall between three standard deviations above and below the mean.

F. Standard Scores

Raw scores are frequently transformed to standard scores to help in interpretation. With standard scores, the mean and standard deviation are constant and known to the user. Any observation expressed in standard deviation units from the mean is a standard score. If the mean and standard deviation are known, the relationship of one score to that of others in the distribution is easily seen.

1. Z-Scores

The z-score is the most widely used standard score in statistics. A z-score of 1.5 means that the score is 1.5 standard deviations above the mean, or a z-score of -1.5 means that the score is 1.5 standard deviations below the mean. Z-scores have the same meaning in all distributions. The mean is always 0 and the standard deviation is always 1. However, because other standard score scales do not involve negative numbers or decimals they are easier to use and interpret. Z-scores can be converted to any other standard score using particular formulas.

2. T-Scores

The T-score is the most commonly used standard-score for reporting performance. T-scores may be converted from z-scores and are always rounded to two figures, therefore eliminating decimals. They are reported in positive, not negative numbers (i.e., 79.8=80). T-scores allow comparison within and among distributions. The mean is always 50 and the standard deviation is always 10.

G. Percentile Ranks

Percentile Ranks compare an individual score to all other scores in the distribution. To find the percentile equivalent for any observation in a normal distribution, the observation is converted to a z-score; the percentile equivalent is then read from a normal-curve table.

H. Correlation or Covariation

A correlation coefficient is a statistical summary of the degree or magnitude and direction of the relationship or association between two variables. Two variables are correlated if they tend to "go together". It is possible to have a positive correlation or a negative correlation. A causal relationship cannot be assumed between two variables being correlated. There are several measures of association.

1. **The Pearson Product-Moment Correlation Coefficient** is widely used in virtually all empirical disciplines. It is also called the "Pearson r" or "r".

2. **The Spearman Rank Correlation** is the degree to which scores maintain the same relative positions or ranks on two measures. Also known as "r ranks".

3. **Scatterplots** are also used to study the relationship between two variables. Each "dot" or "tally" represents the intersection of two scores, or pair of observations, i.e. heights of fathers and sons.

I. Linear Regression

Not only does the correlation coefficient between X and Y on a scatterplot describe the degree of association between X and Y, but this correlation will allow predictions to be made. The purpose of a regression equation is to make predictions on a new sample of observations from the findings on a previous sample of observations, i.e. to predict the height of sons who were not in the original sample, given father's heights. On a scatterplot, when the line connecting the actual means of Y for points all along the X-axis does not differ significantly from a straight line, the regression is said to be linear.

2. Inferential statistics

Inferential Statistics allows the researcher to make an inference about the relationship between independent and dependent variables in a population based on data collected from a sample or samples drawn from the population. To understand inferential statistics, one must distinguish between sample values and population values. When an entire population is not available for study (i.e., all Democrats or all Republicans), the researcher uses a "statistic" (sample value) to estimate a "parameter" (population value). Inferential statistical methods are similar to inductive reasoning - reasoning that goes from the particular to the general, from the seen to the unseen.

Any large collection or aggregation of things that is studied or about which inferences are made is called a population or parent population. A sample is a part, or subset, of a population. The sample should be selected in a deliberate way from the parent population so that the characteristics of the population can be estimated. Most applied statistical techniques are based on the assumption that an infinite population is being sampled.

A. Types of Samples

1. Random Samples

Before a sample will adequately serve as a basis for making estimates of population parameters, it must be representative of the population. If a sample is randomly drawn, it is representative of the population in all respects. A Table of Random Numbers is used for random sampling. Random selection of the members of a sample prevents any selection biases and allows generalizability of the sample findings to the population with a known margin of error (sampling error). Random sampling and stratified random sampling are further explained in the chapter on Research and Evaluation.

2. Systematic Sampling

An example of systematic sampling would be to select every hundredth word in a dictionary which would yield a systematic sample of words, or to select every third student from an alphabetical list. Systematic samples are easier to obtain than random samples and they are also representative samples. However, there is no satisfactory way to determine precisely how accurate the estimates are in the long run.

B. **Sampling Error** is the extent to which statistics vary from the true population parameters and may be due to effects of systematic factors (extraneous variables) or random factors (random fluctuations in subjects or experimental conditions). Due to sampling error, sample statistics deviate from population parameters. The smaller the sample, the greater the sampling error.

C. **An Interval Estimate** is a range or band within which the parameter is thought to lie, instead of a single point or value as the estimate of a parameter. The interval estimate is an important inferential statistical method used in behavioral research.

D. Sampling Distributions

1. **The Sampling Distribution of the Mean** is a frequency distribution, not of observations, but of means of samples, each based on n observations. It is the frequency distribution that would result if random samples of a certain size (n) were drawn from the parent population, the mean was computed for these n observations, then the process was repeated hundreds of times. The frequency distributions of these numerous mean values is the sampling distribution of the mean.

2. **The Standard Error of the Mean** is used as an estimate of the magnitude of sampling error. It is the standard deviation of the sampling distribution of the sample means.

E. Confidence Intervals

As has been stated, 68% of the cases in a normal distribution lie within 1 standard deviation of the mean. The .68 confidence interval is referred to as the 'confidence coefficient' of the confidence interval. However, it is not known if the particular mean that is being studied is one of the 68% that falls within that 1 standard deviation. Thus, it is usually best to have more than ".68 confidence coefficient" so that a wider confidence interval, the .95 confidence interval, is more commonly used. The parameter will then be contained within 95% (19 out of 20) or .95 confidence intervals, in the long run. To be even more confident, the .99 confidence interval is often used (1 out of 100).

F. **Central Limit Theorem** states that the distribution of samples (means, medians, variances, and most other statistical measures) approaches a normal distribution as the sample size, n, increases.

G. **Hypothesis Testing** and interval estimation both look at how inferences regarding the population are made from a sample of observations. A statistical hypothesis is a numerical statement about an unknown parameter. It is either true or false. By using inferential statistical methods, the researcher makes a decision, within a certain margin of error, as to whether the statistical hypothesis is tenable (is accepted) or whether it must be rejected as false. Hypothesis testing is the most widely used technique of statistical inference in educational and behavioral research.

1. **The Null hypothesis** is a statistical hypothesis where the assumption is made that there is no significant difference between means of the variables or groups being measured - that the means of population 1 & 2 are equal. The "no difference" statistical hypothesis is known as the "null hypothesis". Any difference found between means is due solely to sampling error. The null hypothesis is indicated by "Ho".

2. **The T-Test** is widely used to test many hypothesis. It is frequently encountered in published research in many disciplines. The t-test for differences in means allows the researcher to determine whether the difference in two groups is statistically significant. The nondirectional or "two-tailed" t-test is used to evaluate the null hypothesis since it is a "no difference" hypothesis. If the hypothesis is that the two population means are not statistically equal, a directional alternative to the null hypothesis is used, the "one-tailed" t-test. It is more powerful than the "two-tailed" t-test.

Assumptions of the t-test

a. The distributions of observations, in both population 1 and in population 2 are normal.
b. The variance of observations in population 1 and the variance of observations in population 2 are equal.
c. The observations in population 1 are independent of the observations in population 2.

3. **Type-I and Type-II errors** are the two types of errors that can be made in hypothesis testing. Ho can be rejected when it is correct-a Type I error; or Ho can fail to be rejected when it is incorrect-a Type-II error. The prespecified risk of making a Type-I error is usually set at the .05 level of statistical significance, but may be set at the .01 level of significance. If the researcher fails to reject the Ho, a Type-I error cannot be made, but a Type-II error can be made.

H. Types of Statistical Analysis

1. **Descriptive measures** quantify the degree of relationship or correlation between variables. The Pearson Product-Moment Correlation Coefficient (Pearson r) summarizes the magnitude and direction of the relationship between two variables using interval or ratio data. The Spearman Rank Order test is used with rank ordered data. These multivariate correlational techniques include multiple regression, factor analysis and partial correlation.

   a. Parametric tests are used to test hypotheses with stringent assumptions about observations. Observations must be normally distributed in the population, variances of populations are homogeneous and observations in the sample must be randomly drawn. Parametric tests are used with interval or ratio scales. Examples of parametric tests are t-test, ANOVA.

   b. Nonparametric tests are used with data in a nominal or ordinal scale. One cannot assume that there is a normal distribution of data or that there is homogeneity of variances. Examples of nonparametric tests are the Chi-Square test, the Mann-Whitney U test, the Wilcoxon test.

2. **Inferential Statistical Tests.** The primary scientific purpose of statistical methods is to allow generalizations about populations using data from samples. Inferential statistics allows this to happen. Selection of which test to use depends on the nature of the data (nominal, ordinal, interval, ratio) and the design of the research study (one group, multiple groups, one independent variable, multiple independent variables).

   a. The test for nominal data is the Chi-Square test.

   b. Tests for ordinal data are the Kolmogorov test, Kolmogorov Smirnov test, the Mann-Whitney U test, and the Wilcoxon Matched-Pairs Signed-Ranks test.

   c. Tests for interval and ratio data include t-test, Analysis of Variance (ANOVA,) Analysis of Covariance (ANCOVA) and Post-Hoc Tests for the Analysis of Variance.

CHAPTER 13

Outcome Studies

Psychotherapy involves interchanges between one or more therapists and one or more clients. The interchanges, both verbal and nonverbal, focus on understanding what the client(s) is (are) presenting. This understanding, then, is used in an effort to change the clients' ways of thinking, responding to situations, relating to others, and with some therapies, the way the client(s) is (are) feeling.

The results of psychotherapy (outcomes) received little emphasis until the early 1950's when H. J. Eysenck (1952) published an article summarizing twenty-four studies published between 1920 and 1950. In his article, he concluded that there were almost no positive results of therapy. If there were any positive results, he said, they may have been the result of spontaneous recovery. His thesis was challenged by many authors. A number of investigators have since found that psychotherapy is an effective form of treatment (Seligman, 1995). Smith, Glass & Miller (1980) used meta-analysis statistical methods for combining results of several outcome studies published between 1941 and 1976. Their conclusions (and others) were that psychotherapy is an effective treatment, but that no one therapy is consistently superior to any other therapy (Bergin and Garfield, 1994, Altekruse & Sexton, 1995).

Researchers are increasingly studying the effectiveness of therapies that include both psychological and medical interventions. Multi-modal treatment, combining more than one approach, including parts of different psychological therapies is also being studied.

There are many important questions relating to outcome studies. What is the criteria for improvement? Should "improvement" be the therapist's opinion, the behavior or feelings of the client, the opinions of family or friends, or other criteria? How long should changes in behavior or feelings last to be identified as "improvement"? There may be disagreement about the outcome of the therapy between client and therapist and/or others (Dill-Standiford, et al, 1988). It is not unusual for clients to see themselves as "cured" while their therapist sees them as unimproved or even as worse and vice versa.

Other questions relate to how the research is done. What is the measure used to indicate improvement? No reliable criterion of outcome studies is presently available. There are no guidelines for interpreting and analyzing data which is obtained. No long-term studies have been done and would be very difficult given the considerable effort and resources that would be needed. Some mental health problems are both chronic and, in some cases, cyclic, further complicating long-term research.

M. Seligman (1995) suggests the basic methods of studying psychotherapy outcomes:

1. efficacy study - a controlled, "scientific" study, using:
   - treatment-no treatment-placebo groups
   - treatment uses a scripted "manual" for a set number of sessions
   - clients usually meet criteria for a single diagnosed disorder
   - clients are followed for fixed time subsequent to termination
   - treatments not included: family, long-term dynamic, eclectic

2. effectiveness study - studies "in the field"
   - treatment is not of fixed duration
   - treatment is "self-correcting" - if one technique does not work, another is tried
   - clients "shop" for the most compatible therapist
   - clients usually have multiple problems; psychotherapy tries to relieve parallel and interacting problems
   - treatment is usually concerned with "improvements in general functioning" as well as relief of specific symptoms

NOTE

Roth and Fonagy (1996), in their comprehensive review of the outcome literature recognize that there is a range of commonly practiced psychological therapies. "However, there is a marked variation in the extent to which these differing orientations have been subjected to systematic evaluation. The consequence of this fact is that, relative to the frequency with which they are imployed, certain orientations - most particularly psychodynamic therapy - are under represented in (outcome literature)" (p. 32). It is their contention that knowledge of therapy outcomes is mainly knowledge of outcomes from research on therapies other than psychodynamic therapy.

THERAPEUTIC ALLIANCE

The therapist-client relationship is recognized by many researchers as being one of the most important aspects in the outcome of therapy. It is thought that a strong alliance provides a positive aspect to all treatments (Horvarth & Symond, 1993). Roth & Fonagy (1996) conclude that "interpersonal and intrapersonal factors appear to play a part" (p. 352) in the therapeutic alliance. Moras & Strupp (1982) and Kokotovic & Tracey (1990) (as cited in Roth & Fonagy, 1996) have found that clients who have experienced a poor therapeutic alliance and poor therapeutic outcome also have problems maintaining relationships, in general, and have poor family relations. The therapist, of course, is also important in the therapeutic alliance. It may facilitate the therapeutic alliance when the therapist addresses the client's negative feelings toward her/him. The skill of a good therapist may be in their ability to see problems that might make therapy difficult - "the capacity to monitor and maintain the therapeutic alliance" (Roth & Fonagy, 1996, p. 42).

THERAPIST VARIABLES

Although therapist factors in the therapeutic process have been studied, few have been found to be significant in the outcome of therapy. Those therapist factors found to have little, if any, significant relationship include: gender, age, race, specific personality factors, expectations of the therapist.

The following factors, however, have been found to have a greater relationship to outcomes:

Therapist Skillfulness: Therapist skillfulness (not longevity) and the level of therapist mental health make a significant contribution to a successful outcome. When clients specify the cause of positive change, they cite "personal qualities" of the therapist more than specific therapeutic techniques (Altekruse & Sexton, 1995). The ability of the therapist to form a therapeutic alliance is probably the most important therapist attribute in determining outcome (Roth & Fonagy, 1996).

Therapist Experience: There has been found to be a relationship between the experience of the therapist and outcome of therapy. More experienced therapists have better outcomes with more severely disturbed clients than less experienced therapists. Training of the therapist and therapists with more experience may have fewer clients who terminate prematurely and they may retain clients longer in treatment. (Roth & Fonagy, 1996, Altekruse & Sexton, 1995). Experienced therapists may be more comfortable with their techniques, creating a more therapeutic atmosphere. Experience may be particularly important when the therapist varies from the recommendations of a particular technique as well as when working with negative and hostile clients (Roth & Fonagy, 1996).

Therapist Training: There is some relationship between therapist training and outcome. Roth and Fongay (1996) conclude that this may be more true for some therapy modalities than others. They suggest that training in the psychodynamic therapies may necessitate a "fuller" professional training.

CLIENT VARIABLES

Client variables are very important with regard to outcome of therapy. It is seen as "a truism" that "psychological therapy requires the active participation of the (client) . . . a coordination of effort between (client) and therapist" (Roth & Fonagy, 1996, p. 42). In the research, it seems that client characteristics are better indicators of therapy outcome than other components such as characteristics of therapists, client-therapist match, or treatment variables (Frank, 1974; Luborsky, et al., 1980 as cited in *Preparatory Course for the Psychology Licensing Examination*, Vol. IV, 1991). As with therapist variables, no clear and consistent findings have been found with a number of client variables (although more is known of the impact of client variables on outcome than of therapist variables). Client variables without clear findings include: gender, age, marital status, race, social class.

Client Diagnosis: Some researchers have found that clients with severe diagnoses such as schizophrenia showed less improvement than those with more narrow diagnoses such as phobias or specific anxieties (Horowitz, Marmar, Weiss, DeWitt, and Rosenbaum, 1984 as cited in L. Seligman, 1990). Other research has found that clients with depression or anxiety may, at least at the beginning of treatment, tend to improve the most, but those with somatic problems showed less improvement (Frank, 1974; Luborsky, et al., 1971 as cited in *Preparatory Course for the Psychology Licensing Examination,* Vol. IV, 1991). Pilkonis, Imber, Lewis, and Rubinsky (1984) found that chronicity of the emotional disorder was predictive of a poorer outcome.

Client Perceptions: Client's perceptions of the therapist's abilities to be helpful and encouraging, to help them face and understand their problems and themselves were seen to be important in the outcome of therapy (L. Seligman, 1990). Strupp and Bergin, (1969) conclude that clients who see their problems as psychological (not medical), and who expect therapy to be an active process are more likely to have a positive outcome.

Client Attractiveness: Studies have found that clients that were thought of by therapists as attractive and likeable generally had the most success in therapy (Nash, et al., 1965 and Strupp and Williams, 1960 as cited in *Preparatory Course for the Psychology Licensing Examination,* Vol. IV, 1991)

Client Intelligence and Education: More positive outcomes have been found to be associated with higher levels of intelligence and higher educational levels (Luborsky, et al., 1985, Ware, 1978).

TREATMENT FACTORS

Treatment Factors in therapy have been investigated.

Type of treatment - Overall, no one type of treatment has been found to be the best. However, a substantial amount of evidence has been found for the use of specific treatments for particular disorders (Roth & Fonagy, 1996, Altekrase & Sexton, 1995). For example, clients with panic disorders, agorophobia, and depression respond best to cognitive or cognitive-behavioral therapies sometimes in conjunction with medication; social skills training is used with persons with avoidant personality disorder. It seems to be the case that it is not the general theoretical approach, but the clinical protocol used with certain client problems that is important for successful outcomes. Clinicians may need to be trained in several different therapies in order to best treat clients with differing problems. Although the evidence is not clear that cognitive-behavioral and behavioral treatment is best for all diagnoses, insurance companies and HMO's generally tend to favor these treatments.

Length of Treatment - Some studies have found that, generally, there is no substantial difference between long and short-term therapy. Other studies have shown improvement levels off at about twenty-six sessions. However, when present and former clients were asked about the effect of the length of therapy in the *Consumer Reports* study, long-term treatment was seen to produce more improvement than short-term treatment. The greater amount of time (from 1 month or less to more than 2 years), the greater the improvement score (M.E.P. Seligman, 1995). The relationship between long or short-term therapy and a particular problem has not been reported.

Preparing Clients for therapy - Some studies have found that preparing clients for therapy prior to starting results in more positive therapy outcomes. Role preparation of the client by the therapist has an impact on the counseling outcome.

In General: It has been suggested that clients who are appropriately prepared for their role, who are viewed as suitable for treatment, who become engaged in a process of talking to the counselor whom they view as skillful, benefit from counseling (Seligman, M.E.P., 1995; Whiston & Sexton, 1993).

OTHER CLIENT ISSUES

1. Client drop out

A significant proportion of clients drop out prematurely, particularly lower socioeconomic clients. ". . . factors associated with premature termination include conventional, uncompromising views (e.g.: conformance with gender-role stereotypes), lack of anxiety regarding their problems, low levels of psychological sophistication or insight and they may be authoritarian. Other factors may include a high need for approval, lower education level, minority group membership and the expectation that the therapist will provide specific advice. Factors contributing to a client staying in therapy include the client tending to have high levels of perseverance, social integration, suggestibility, and anxiety. They may also have a low impulsivity level and an absence of antisocial or authoritarian attitudes" (*Preparation Course for the Psychology Licensing Examination,* Vol. IV, 1991 p. 48).

Active "therapist-shoppers" and active clients did better in treatment than passive recipients in the Seligman study (1995).

Seligman found that people whose choice of therapist or duration of treatment was limited by their insurance coverage did worse in therapy than those for whom this was not the case (M.E.P. Seligman, 1995).

CHAPTER 14

Prevention

Factors in the development and prevention of the psychiatric disorders.

PRIMARY TYPES OF FACTORS

1. Risk factors

The greater the number of risk factors to which individuals are exposed, the higher their susceptibility is to mental illness. Risk factors create stress on the psychic systems. When too much stress is applied the mental systems break down. Some risk factors are:

- Chronic illness
- Substance abuse
- Marital discord
- Handicaps or disabilities
- Low self-esteem
- Lack of insight
- Occupational stress
- Economic distress
- Problems with children
- Undiagnosed learning disability
- Unemployment
- Lack of leisure time
- Frequent relocations
- Shyness
- Social isolation
- Serial losses
- Social skills deficits
- Communication impairment in childhood

2. Protective factors

Protective factors reduce the possibility of the development of mental illness. The protective factors provide a buffer to and a way to deal with risk factors.

- No family history of psychiatric disorder
- No family history of debilitating medical illnesses
- Good physical health
- Regular exercise
- Intelligence
- Secure attachments to others
- Ability to tolerate intimacy
- Flexibility
- Open communication system
- Personal autonomy
- Clear boundaries
- Job satisfaction
- Financial security
- Academic achievement
- Social support systems
- Social skills
- Parental warmth
- Appropriate discipline as a child
- Bonding to family or other social models
- Effective coping skills
  Activity oriented
  Introspection
- Uses social/family supports
- Thinks through problems
- Searches for a greater meaning

OTHER TYPES OF FACTOR SYSTEMS

1. Developmental factors

The role of developmental processes across the life span in influencing the impact of these risks and protective factors and in shaping the process by which individuals develop resilience in the face of severe environmental stressors are of importance:

- An awareness of lifespan development
- The emergence and course of psychopathology
- Stress on developmental processes rather than single, static variables
- Identify specific risks at various points along the life span
- Design prevention interventions to reduce risk factors before they become entrenched
- The adaptive fit between the person and their environment

2. Cultural factors

Cultures differ in the definition of adaptive behavior and life span development. What is appropriate in one culture may be aberrant in another. It is important for the counselor to be aware of the differences in their clients' cultural norms.

3. Community factors

Rural societies, synonymous with the village, clan or extended family, will have different risk and prevention factors than the urban community where neighborhoods are tied by social forces such as ethnic or economic factors. Community prevention programs need to be developed by the culture in the community. The counselor needs to be in touch with the stressors and protective forces in their community.

4. Institutional factors

Schools - A preventative factor in the school would be the reduction of psychological stress associated with transfer to another school or into a new high school by the family or school staff. One intervention of the school counselor might be the maintenance of stable and supportive peer relationships among incoming students.

5. Occupational settings

Vary in the degree in which they support or subvert mental health. There are many systems at play on the job such as the nature of the "corporate culture," the services offered via health insurance or employee assistance programs as well as the nature of the work itself.

6. Family factors

The passage from one family developmental stage to another, the relationships between the marital partners or family executive system, and the parenting styles are a few of the factors residing in a family. The counselor needs to assess the family of origin as well as the current "family" to understand all the family factors.

7. Peer factors

- Positive peer relationships support mental health.
- Lack of peer support subverts mental health.
- Identification with delinquent youth groups promotes the development of psychopathology.

8. Biological factors

- Single and multiple gene risk and protective factors.

- Early menarche predisposes teen pregnancy. Some data suggests that family conflict, severe psychological trauma and father absence may precede, and possibly induce early menarche and its attendant hormonal increases.

OBJECTIVES OF PREVENTION

1. Prevention of mental health disorder

These objectives are measured by:
- The incidence of mental disorder.
- Reduction of the symptoms experienced among pre clinical cases.

Interventions can be enhanced by:
- Fitting intervention strategies to subsets of populations at risk.
- Increasing the acceptability of the interventions in order to minimize refusal rates.
- Increasing the cost effectiveness of interventions.

2. Reduction of risk and enhancement of protective factors

Protective factors can be enhanced by:
- Mental health promotion
- Clear definitions of mental health.

STRATEGIES OF INTERVENTION

1. Developmental timing

Finding "windows of opportunity" for appropriately timed interventions, making them more effective.

2. Focusing the intervention

Choosing the appropriate focus of an intervention, i.e., should an entire school be provided with a drug education program or should particular school populations be addressed in a planned series of interventions.

3. Precise identification of populations at risk

The more accurately a population at risk can be identified the more effective the prevention intervention will be. The population needs to be assessed for:
- The effectiveness and efficiency of the intervention.
- The readiness of relevant persons in the setting to continue to deliver a successful intervention after the trial is concluded.

CHAPTER 15

Career Development

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Career, in the United States, is "increasingly being defined as the combinations and sequences of life roles, the settings in which life roles unfold, and the planned and unplanned events that occur in people's lives." (McDaniels and Gysbers, 1992) As clients seek a context and meaning in their life, their vocation or career becomes evaluated for its appropriateness in meeting their life needs.

HISTORY

The evolution of career development can roughly be divided into four major periods:

1900-1950 - This period encompasses the industrial revolution and saw the development of "vocational guidance." This term was coined by Quincy Agassiz who established the Civic Service House in Boston in 1908. The focus was on how to choose work and "build a career."

1950-1980 - A broader, developmental view of work began during this period. The term "vocational development" was used frequently. More professionals began to enter the field and in 1966 the National Vocational Guidance Association was formed. Career development was defined as "the total constellation of psychological, sociological, educational, physical, economic, and chance factors that combine to shape the career of any individual." (McDaniels and Gysbers, 1992) The focus became more longitudinal rather than "what job will I choose next?"

1980-1990 - Up until this time the world of work or career was compartmentalized and considered to be separate from other life roles. During this period the work would began to be seen as an integral part of "life." Career consultation began to focus on "life-career" development.

1990 to present - The relationship between life and work continues to be redefined and clarified. Work is viewed over the life span.

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HOW CAREER DEVELOPMENT IS INTEGRATED INTO THE COUNSELING PRACTICE

1. Career issues are often prominent in the counseling setting:

A. The company may be paying for mental health benefits.

B. The client may have been referred for evaluation by their manager.

C. They may have just lost a job.

D. They may be unhappy with their current job.

E. They may be addicted to their work and find it is impacting their health and other roles.

F. They may be seeking a higher quality of life which means a better, more fulfilling job.

2. The following framework for addressing career issues is structured after Gysbers and Moore (1987).

A. First

1. Identify the client goal or problem
2. Clarify the client-counselor relationship
3. Define the client-counselor responsibilities

B. Second - Gather information

1. How does the client view self, others and their world?
2. What themes does the client use to organize and direct their behavior?
3. What are the client's current status and environment like?
4. Do appropriate testing.

C. Third - Clarify client goals or problems.

D. Fourth - Develop individual career plans.

E. Fifth - Evaluate the results.

If the client has entered counseling to specifically address career issues this model can be followed. If career issues become a focus, related to other, more difficult issues, this model can be used as it is appropriate.

CAREER THEORIES

1. Decision models

Focus on how decisions are made and the criteria that are used. The factors that might affect decision making are:

A. The belief of self efficacy and self-esteem.

B. Risk taking style and comfort zone.

C. Values.

D. Investment of time, money or other resources.

2. Developmental models

Show process of change over time and influences that change lifestyle and career.

3. Sociological or situational models

Sociologists advocate that career development and career choices are influenced by the environment. The individual's choices are also influenced by their family, community, culture and social class as well as the geographical setting. These factors determine what a person is aware of, determines their risk taking behavior, and provides work identity and career mobility.

4. Structural models

Structural models measure and define individual differences in career in developmental terms. This information is then used to predict success in educational or vocational arenas. An example of a structural theory is trait-factoring. Developed by Frank Parsons (father of guidance) and author of "Choosing A Vocation" (1909), often called an actuarial or matching approach. This approach stimulated the development of assessment techniques and occupational information gathering. The trait-factor means you:

A. Study the individual.

B. Survey occupations.

C. Match the person with an occupation.

5. Needs based

Career is matched to individual needs.

6. Personality based

The best work situation is identified through the personality factors of an individual.

7. Cognitive theory

Comes out of the work in cognitive psychology. This approach looks at the biophysiological, linguistic, and psychological processes that form the cognitive functioning.

8. Comprehensive model

Encompasses all of the above.

LEADERS IN THE FIELD

1. Decision making models

H. B. Gelatt believed that the decision making process went on continuously and was constantly revisited. The process he outlined follows.

A. Recognizing the need for a decision.

B. Gathering data.

- Identifying possible courses of action.
- Considering the outcomes of each action.
- Reviewing values and if they are being supported in the possible outcomes.

C. Making a decision that may be a final decision or a decision in a series of decisions.

2. Developmentalists

A. There are four major developmentalists

1. Axelrad
2. Ginzberg
3. Ginsburg
4. Herma

B. These developmentalists share the belief that occupational choice progresses through three periods:

1. Fantasy - birth to 11 in which play becomes work oriented.

2. Tentative 11 - 17 which is made up of four stages:

   Interest
   Capacity
   Value
   Transition

3. Realistic 17+ with three stages

   Exploration
   Crystallization
   Specification

C. Linda Gottfredson

1. Gottfredson's theory is called "circumscription and compromise." She believes:

   a. Self-concept is an important factor in all career choices.
   b. We develop a range of acceptable work alternatives.
   c. We select occupations within those alternatives that are compatible with our self-concept.
   d. We rule out occupations through:

      - Sex typing
      - Staying within our social class
      - Inappropriate intelligence level, not able to succeed
      - Inappropriate interests based on an arbitrary value system

2. Her developmental stages are:

   a. Orientation to size and power ages 3-5
   b. Orientation to sex roles ages 6-8
   c. Orientation to social valuation ages 9-13
   d. Orientation to internal unique self ages 14+

D. Donald Super

Super was one of the early founders in the field of career consultation. He is very well known for his extensive involvement in the field. He has done longitudinal studies of students starting in the 9th grade and following them well into their 30's.

1. Super's general development process includes:

   a. Growth - birth to 15 years
   b. Exploration - 15-24 years
   c. Establishment - 25-44 years
   d. Maintenance - 45-64 years
   e. Decline - 65+ years

2. Super delineated five vocational tasks:

   a. Crystallization - 14 - 18 years
   Formulating a general vocational goal.

   b. Specification - 18 - 21 years
   Moving from a tentative to a specific vocational choice.

   c. Implementation - 21 - 24 years
   Completing training and entering employment.

   d. Stabilization - 24 - 35 years
   Confirming a preferred choice by performing the job.

   e. Consolidation - 35+ years
   Becoming established in your career, advancing and achieving status.

3. **Super created the concept of life-career rainbow.** The rainbow includes the life span with its major stages and life space, made up of the roles we play. He identifies these roles as:

   a. Child
   b. Student
   c. Citizen
   d. Spouse
   e. Homemaker
   f. Parent
   g. Worker
   h. Leisurite
   i. Pensioner

3. Personality based

John Holland was a major proponent of personality based ideas. He believed a career choice was an expression of the individual's personality. He believed we choose a career based on the stereotypes we hold about different jobs or careers. Holland's typology includes six styles or types which are seen in the Strong Campbell assessment instrument.

A. Artistic

Creative and imaginative. Prefers self-expression through the physical, verbal or other media. Dislikes systematic and ordered activities.

B. Conventional

Practical and prefers ordered structured activities. Dislikes ambiguous and unsystematized tasks.

C. Enterprising

An extrovert that prefers leadership and persuasive roles. Dislikes abstract or cautious activities.

D. Investigative

Intellectual and prefers systematic creative investigation. Has poor persuasive and social skills.

E. Realistic

Aggressive and prefers explicit tasks requiring physical manipulation; has poor interpersonal skills.

F. Social

Prefers activities that inform, develop or enlighten others. Dislikes activities involving tools or machines.

4. Needs approach

A. Robert Hoppock

Hoppock placed high value on the identification of individual needs. He believed that if the person was clear about their needs, researched and became familiar with the occupations that were available to them, they could then make a good match and choose the right work. He believed that a person's needs changed over time so no single work event would last throughout a lifetime. As the needs changed, the work needed to change to meet those needs.

B. Ann Roe

Roe focused on the early childhood experiences that affected our adult needs. She also believed that careers were chosen to satisfy our needs. Roe developed a six "field-by-level" classification system:

1. Occupations:

- Professional and managerial - highest level
- Professional and managerial - regular
- Semi-professional and managerial
- Skilled
- Semi-skilled
- Unskilled

2. Fields:

- Service
- Business
- Managerial
- General cultural
- Arts and entertainment
- Technology
- Outdoor
- Science

5. Cognitive model

This model uses three basic organizers:

A. Structural Organization

How information is processed by the individual. This processing defines how they perceive themselves and their world.

B. Developmental Sequence

Differences in ways of thinking
Dualism - simplistic black and white thinking
Multiplicity - outer locus of control but includes multiple factors
Relativism - internal locus of control able to consider various options
Commitment within relativism - career identity and self become integrated.

C. Interactionism

The interaction between self and the environment (McDaniel and Gysbers 1992)

6. Comprehensive model

John Crites developed the *Career Maturity Inventory* and a comprehensive model of career counseling that includes three diagnoses of the career problem. After the diagnosis he suggests beginning with client-centered and developmental counseling, followed by psychodynamic techniques such as interpretation, followed by trait-factor and behavioral approaches. The three diagnoses to be made are:

Differential - what are the problems?
Dynamic - why have the problems occurred?
Decisional - how are the problems being dealt with?

CAREER COUNSELING COMPETENCIES

Consultation
General counseling
Implementation
Individual/group assessment
Information on education, training, employment, labor market and career resources
Management/administration

COMPUTER ASSISTED CAREER GUIDANCE SYSTEMS

C-LECT -	Computer-Linked Exploration of Careers and Training
COIN -	Coordinated Occupational Information Network
GIS -	Guidance Information System
SIGI PLUS DISCOVER -	System of Interactive Guidance and Information files

KEY TERMS

1. **Career** - a series of jobs and occupations one does.
2. **Career adaptability** - originally identified by D. Super as career maturity.
3. **Career counseling** - emphasizes career development paying attention to personal values and attitudes at work in a dynamic environment with a focus on self understanding, career information, planning and decision making.
4. **Career development** - a lifelong process in which we develop values, skills, interests and knowledge of the world of work.
5. **Career guidance** - a service that assists individuals in understanding and acting on their knowledge of self and of opportunities in work, education, and leisure.
6. **Career pattern study** - Super examined the vocational behavior of 9th graders all the way into their 30's.
7. **Differentiation** - becoming unique or different based on one's biology and the environment.
8. **I-power** - potential for self-improvement.
9. **Expressed interests** - those spoken or reported.
10. **Integration** - striving to become accepted or integrated in one's career.
11. **Job** - one person in one position doing a set of tasks.
12. **Lifestyle** - the person's orientation and preference in regard to career, family, leisure, place of residence, work climate, and overall style of life.
13. **Manifested interests** - determined by examination of what one is studying, previous jobs held and activities enjoyed.
14. **Occupation** - a definable work activity found in many locations.
15. **Outpatient counseling** - counseling provided to workers who are to be terminated.
16. **Retirement counseling** - counseling to assist people examine their options following employment.
17. **Vocational maturity** - J. Crites - a continuous developmental process moving through a series of stages and tasks. Tested interests - measured via inventories.

CHAPTER 16

Organizational Consulting

Consulting with an organization is a natural application of the counselors skills. When entering into a consultative role, either in your office or on-site at a business you still must maintain the highest ethical standards possible.

ETHICS OF CONSULTATION

Consultation by a practicing clinician holds the potential two major ethical issues:

- The site where you are consulting has current or former clients.
- The ethics of the consulting role which holds an identification of power.

The following are guidelines to follow when in the role of "consultant" (Corey, Corey, Callanan, 1991).

- First the consultant needs to be clear about who the "client" is. This is the person to whom the consultant owes primary allegiance. When working in an organization department managers may have different needs than the identified "client."
- As in the counseling relationship, the consultant must be alert to creating a dependent relationship. The job is to assist and provide expertise, not create a dependency.
- Cultural issues may be obvious in a company that is predominately ethnic or not so obvious as in a "corporate culture." The consultant must be informed of the cultural norms when the culture can be clearly identified, and seek out the cultural norms when they are not clearly seen.
- If a consulting client asks to become a clinical client, the situation must be clearly explored and a solution be found that meets the client's needs and remains an ethical solution. The consultant must maintain well-defined limits, and if the individual is in need of clinical help refer them to outside resources.
- If unbeknownst to the consultant, a previous client is at the worksite, information about the interactions must be entered into the closed client files. The highest integrity must be maintained at all times by the clinician/consultant.

THE RIGHTS OF CONSULTEES

1. Confidentiality

Before gathering any data the consultant needs to clarify and come to an agreement about who has a right to know the information gathered. These agreements are best made in writing between all parties involved. As in any situation when there is a danger to self or others, it is the consultant's responsibility to report the risk.

2. Informed consent

The following information needs to be included in the consultant's informed consent:

- Goals and process of consultation.
- Limits to confidentiality, such as above.
- The voluntary nature of consultation.
- Potential benefits.
- Potential risks.

The best way to approach informed consent is for consultants to ask themselves what they would want to know if they were in the clients' position. (Corey, Corey and Callanan, 1991)

ORGANIZATIONAL DEVELOPMENT CONSULTATION COMPETENCIES

1. Conceptual knowledge and theory

Organizational consultation is an alternative arena for the applied behavioral sciences. Organizations are systems so the system theorist is also at home here. In addition to the behavioral sciences the competent consultant also needs knowledge in management science, research methods and organizational change.

2. Self awareness

Like the counselor, the consultant uses the "self as instrument." He/she must be committed to the use of his/her skills and expertise while simultaneously being disengaged from the process. Self-knowledge about his/her own history, biases and world view as well as how they impact these consultative process are vital.

3. Consulting skills

Consultation includes, and is more than, listening well, observing what is not spoken, responding and putting agreements and thoughts into a written form. The consultant is also often asked to manage conflict, mediate and facilitate a group process. The successful consultant must also be able to market, contract and manage money and information.

4. Business and industry knowledge

The effective consultant must understand business language, principles and general practices. Many of the consultant skills are general to the consultative process and knowing something about the industry is also vital. Some consultants specialize in working with clearly identified industries such as health care, banking or hi-tech industries. (Winge, 1986)

THE CONSULTIVE PROCESS

An organization is much like a family. Organizational consultants deal with the needs of the organization much as they would deal with any system of people. The following general model can be used when working with an organization. After each stage the kinds of questions ethical consultants must ask themselves are posed. Following the general model is a list of specific approaches developed for the consultative process.

1. General stages of consultation

- Assess the needs of the organization. Do you have the skills to meet these needs?
- Create goals for the consultation. Are the companies goals ones you can ethically pursue?
- Plan how the goals are to be implemented. Do you have the expertise to implement or will you need outside help?
- Identify the management structure and how it will be impacted by the goals. Is the system strong enough to withstand a change in management structure? Is pre-change work required to safely create the management change necessary to implement the goals?
- Plan for the change process. Is the organization ready to create the changes needed?
- Identify areas of expected resistance. Do you have the skills to deal with the resistance and/or mediate problems?
- Pre-test. Are you qualified to administer the tests?
- Train. Can you provide the training needed or will you need outside help?
- Maintenance. How is change to be maintained? Do you need another contract for this process? Are you creating a dependent relationship?
- Analyze consultation and change process. What are the outcomes? Are they consistent with what was targeted initially?
- Post-test. Is the post-test testing correctly or is it designed to provide the answers you want?
- Reengineer activities based on outcomes. Now is the time for a reassessment of your skills and how well they have served the client.

2. Consultive models

A. Doctor-Patient Model

The consultant advises the customer about what is wrong and what should be done about the situation. This model is called the Doctor-Patient model because it is a parallel to a doctor diagnosing the patient's problem and providing a prescription to cure the problem. This model does not require a change or "cure" in the group.

B. Expert or Provisional Model

With this model the consultant acts as the "expert" and provides direct service to consultee who has hired them because they do not have the skills to deal with the problem at hand. The advantage of this approach is that it allows the consultee to step away from the problem while the "expert" solves it. The disadvantage of this model if the solution is successful, the consultee who hired them will get the credit for hiring the consultant and solving the problem. If the solution fails, the blame goes to the consultant.

C. Mediation Model/Systems Approach

Using the mediation process the consultant acts as a coordinator. The goal is to identify the services available from the variety of people who are there to solve the problem. The consultant may offer alternative plans that represent a mutually acceptable combination of several solutions. Mediation is a systematic method of problem resolution using resources that are already available within the system. This approach is thought to minimally disrupt the current system.

D. Collaborative Model or Process Consultation

This consultant is a facilitator for the problem solving process. The consultant gets the client to actively discover solution alternatives to their situation. In order to do this the client must define their problem clearly, analyze it thoroughly, identify workable solutions, choose and implement the solution of choice. The secondary goal of this method is to train the client to become more aware of their choices and increase their awareness of their own problem solving and decision making styles.

E. Group Consultation

Groups who have common tasks or problems often get stuck and need a consultant to help them get moving again. The primary purpose of this model is to provide new knowledge about human behavior to the group, and encourage them to work together. Caplan's C-Group model which follows, is an effective tool for this environment. (Caplan, 1994)

Caplan's Stages of Consultation - C group

- **Collaboration** - encourages members to work together as equals.
- **Consultation** - members must actively give and receive input from one another.
- **Clarification** - members must understand the relationship that exists between beliefs, feelings, and actions.
- **Confrontation** - members openly share constructive feedback.
- **Concern** - empathy for other members, their perspectives and situations is required.
- **Confidentiality** - keeping information within the boundaries of appropriateness is key.
- **Committment** - planning and implementing specific actions are necessary for completion of this model.

F. Agency Consultation From A Prevention Model

Agency consultation began in 1963 formally as a result of the passage of the Community Mental Health Centers Act. Included in the act is the philosophy that mental health is viewed from a local community perspective with an emphasis on prevention. The following is a prevention model as outlined by Caplan (Caplan, 1944).

Level 1 - First Level Goal - reduction in the number of mental disorders. This goal is reached by teaching life coping skills in the community. Consultation is a primary activity at this level.

Level 2 - Secondary Prevention Goal - reduction in the duration of mental disorders. This goal is reached by working with individuals to deal with their problems and increase support systems. This involves the treatment process.

Level 3 - Tertiary Prevention Goal - a reduction in the impairment that may have resulted from psychological disorders. The more success achieved at levels 1 and 2, the less need there is for level 3.

CHAPTER 17

Professional Practice

This chapter includes generally accepted guidelines for Professional Practice. In order to practice, you need to know the specific regulations that apply to your State or Regulatory agencies.

QUALITY OF CARE

As a professional it is your responsibility to provide the highest quality of services possible. If you do not you are vulnerable to a claim of substandard or negligent treatment. The malpractice insurance you carry protects you from liability lawsuits that are based on "negligence theory." You can be found guilty of negligence through commission or omission of treatment. It is your responsibility to constantly scrutinize your professional services. If you are offering, or failing to offer services as they are recommended by your professional association, but are not in the best interest of your client, you bear the consequences. The definition of "quality care" is a combination of "beliefs, attitudes, mores, values, ethics and laws. . ." (Woody, 1997) If you decide a particular kind of treatment is helpful to your clients, it is not entirely your decision to make. That type of treatment must be judged to be useful, and tested to be useful, through some form of scholarly peer review.

1. Scope of practice

The scope of your professional practice is defined by the Professional Associations you belong to, your Certifying Board, and the Regulatory Board in your state that provides you with a license. States have differing situations with certifications, practice laws and title laws. This means that your scope of practice may only include the use of a professional identification, or it may cover what you can and cannot do while providing services. It is your responsibility to know and understand how your work is defined by all the above.

You are legally bound to operate within your "scope of practice." As stated above, "scope of practice," may be defined for you by others. More specifically that means you may only provide services for identified areas in which you have adequate training, experience and competence.

Insurance

When you are working with clients who are using their mental health insurance you must also abide by the regulations included in the contracts under which you agree to be reimbursed for services.

UNPROFESSIONAL CONDUCT

A counselor must abide by their "scope of practice" and any other regulations affecting how they practice their profession. What follows are general guidelines for behaviors to not engage in, and some suggestions how to make certain others know that you are practicing in a professional manner.

1. Credentials and qualifications

A. Misrepresenting the type or status of license or registration held by the licensee or registrant.

Have your license, certification or registration and any other business practice certificates displayed on the wall in your office.

B. Impersonating a licensee or allowing another person to use your credentials.

Make certain when you sign all contracts and insurance forms, you indicate how you are practicing. If you are billing under a supervisor's name, make certain that is clear.

C. Aiding and abetting an unlicensed person to engage in conduct requiring a license.

If you are supervising interns, make certain they do not misrepresent their status.

D. Misrepresenting or permitting the misrepresentation of your professional qualifications, affiliations, or purposes.

If somebody verbally or in writing misrepresents you, clarify the issue in writing.

Claiming an area of "specialty" without formal training or having skills that are greater than the average clinicians.

E. Performing or presenting yourself as able to perform professional services beyond your field of competence as established by your education, training or experience.

Maintain good records of all continuing education that enhances your services.

F. Advertise in a manner that is false or misleading.

Make certain all advertisement copy is proofed before it is printed and distributed.

2. Practice standards

A. Not following the ethical standards of your profession.

You are bound to the ethical standards of your profession even if you are not a member of the association.

B. Intentionally or recklessly causing physical or emotional harm to a client.

It is recommended that you always work with a supervisor or consultant with whom you can discuss questions and concerns that arise during the course of your work.

C. Not making a diagnosis and treatment plan for a client.

Therapy must be "academically and scientifically based." Every one of your clients should have an "individualized" diagnosis and treatment plan. If you choose not to do this you must have an academic and/or scientific construct to support your approach.

D. Committing any dishonest, corrupt, or fraudulent act that is substantially related to the qualifications, functions or duties of your license.

Always act honestly in any clinical or business interaction.

E. Encouraging a client to use your counseling services rather than anothers, or encouraging them to leave therapy with another therapist for your services.

If you believe there is unprofessional behavior occurring, and a client is at risk, you are required to report that professional to their licensing board and their professional organization. If you believe a client is not receiving the treatment they need that is not grounds for reporting in most states. In any case, do not involve the client.

F. Having sexual relations with a client.

NO NO NO NO - and if you know of anybody who is, report them as above.

G. Failing to maintain confidentiality, except as otherwise required by law.

Make certain your clients know during the first interview their rights and your requirements regarding reporting laws and when you are required to break confidentiality.

H. Prior to the commencement of treatment, failing to disclose to the counselee, or prospective counselee, the fee to be charged for your professional services, or the criteria upon which such fees will be computed.

Include this information in your initial Statement of Professional Services and ideally have all client's sign it.

I. Accepting additional fees from your client for services performed at a location that is reimbursing you for your professional services.

Do not seek additional reimbursement from a client beyond your wages.

J. Sexual harassment.

No no no no

K. Taking care of your personal needs at the expense of the client.

It is highly recommended that you partake of supervision of some kind, peer, group or individual, while practicing to ensure you are always seeking to provide the highest standard of quality possible. The more expert the supervisor the better.

L. Allowing your personal life to become part of the therapeutic relationship.

Having an office in your home is often a problem if the office in any way interfaces with your living quarters. The safest situation is an external office.

It is recommended that you do not give your home number to clients. Maintain a separate business telephone number.

M. Continuing to care for a client who is not making progress.

If a client is not making progress, completing prescribed homework assignments, or participating in the treatment contract it is the responsibility of the clinician to advise them if they do not follow the prescribed treatment plan they may need to terminate treatment or make an appropriate referral.

MALPRACTICE

The following have been considered grounds for the filing of a malpractice claim. The actions you might take to make certain this does not apply to you are included:

1. Negligent evaluation

An evaluation must be made within the first three visits, unless the first contact is a crisis. There should be a clinical evaluation and working treatment plan in place by this time.

2. Abandonment

Let your clients know what you will do in your "informed consent" information when their insurance runs out or they find they can no longer pay for your services. Ultimately, you are responsible for their care until you can find them alternatives. If you have provided them with at least three alternatives, and they have chosen not to follow up on them you have fulfilled your obligation as a provider. Make certain you document all your attempts to help them obtain alternate services before terminating your services.

3. Inadequate care or treatment

It is highly recommended that you engage in personal supervision or consultation while you are providing professional services to ensure all treatment options have been explored.

4. Failure to obtain informed consent

Create a document that describes all the information under client's rights and have your client read and ideally sign a copy.

5. Breach of confidentiality

When in doubt, do not discuss clients and make certain your records are properly protected at all times.

6. Breach of contract

If any changes in your initial agreements happen, make a written record and have your client sign a copy for your records.

7. Useless treatment

If your client is not making any progress you might consider:

- Discussing it with your supervisor or consultant
- Making a referral to another professional
- Terminating treatment

8. Dual relationship

A. **Do not enter into any other relationship with a client who is engaged in counseling with you.** Any other relationship you have with a counseling client in any other arena is considered a Dual Relationship. There have been some time frames identified pertaining to when you can develop a different relationship, such as a friendship (2 years) by state law and professional group. In general, it is a good idea to just say no. Some examples of dual relationship are:

1. **Business relationships**

If you are already involved with someone in a business arena and they ask you to do therapy for them, or a member of their family, you may act in an information and referral capacity only. The business relationship precludes a therapeutic relationship. A therapeutic relationship precludes a business relationship.

2. **Sexual relationships**

Includes former clients. The length of time after therapy has not been made clear. The best time frame is never.

3. **Personal relationships i.e., friendships**

Some states provide legal guidelines about how long a clinician must wait before entering into another role with the client. The safest decision is to never enter into a relationship of any kind with a former client.

4. **Tradeout or bartering**

The only form of "currency" that cannot be misjudged in its value is money. No other form of payment should be received for services rendered.

5. **Accepting gifts**

The wisest decision is to decline any gift offered and view the offering of a gift within the clinical framework.

B. If a dual relationship is unavoidable, the following has been offered as a way of handling the situation:

- Secure informed consent.
- Seek consultation.
- Document and self-monitor.
- Obtain supervision.

LEGAL ETHICAL

The individual counselor carries the responsibility of reporting laws that have been created by national and local, regulating agencies, professional laws, business codes, and pertinent legislation. It is your responsibility to be familiar with all of these regulations. It is also the individual's responsibility to honor his/her own conscience and to always keep the best interests of clients, colleagues and society in mind. In most current cases, if you are told to break or breach a law or code by your employer, supervisor or any person in authority in the arena in which you are acting, and the case is brought to court, you will be held personally responsible for your actions. Also, if you are working in a location, or are a member of a group counseling practice and have knowledge of abuse that is going unreported, you may be held liable if you fail to report.

1. Vicarious liability

If a clinician is in any kind of business relationship with another mental health professional he/she are subject to vicarious liability of the other clinician's practices. If the practice appears to be combined, the liability increases. When in relationship with another professional it is recommended there be full disclosure regarding:

- Substance abuse
- Management of personal finances
- Sexual relations.

2. Client's rights

Informed Consent

When you consider working with new clients there is some information they should be provided with in order for them to make an informed decision about whether or not they want to enter into a professional relationship with you. Some of the information it is recommended you should provide in writing is:

A. The cost of treatment.

If you use a sliding fee schedule they need to know the criteria you use to determine their fee. Other billing information you should provide them with is:

1. Your method of billing.

2. How you would like to be paid (per visit, monthly, through insurance).

B. **How many visits you believe this particular phase of treatment will include.**

C. **How many visits are covered by their insurance carrier,** what their co-payment, deductible or other prior payment requirements may be and what you will do if they wish to continue in treatment and no longer have insurance coverage. These policies must be congruent with any contract you may have with their insurance carrier.

D. **What type of counseling services you provide.** Help them to understand the type of interventions or lack of them they are to expect. How much of the work is their responsibility, i.e., keeping a journal, bibliotherapy.

E. **The advantages and disadvantages of counseling.**

F. **The potential risks of counseling.**

G. **The potential effect it may have on their immediate or extended family, job, social activities, or other aspect/s of their life.**

H. **Alternatives to counseling.** This might include community services that are available.

I. **When you break confidentiality, i.e., danger to self or others.**

J. **How and when you may be contacted (i.e, emergencies, vacations).**

3. Duty to warn (general)

When a client is a danger to themselves or others, there is an exception to the privilege and the therapist is permitted, and sometimes mandated by the state, to confide in someone else to protect the client and the public. Make certain that you know the reporting laws in your state.

A. Risk of Suicide

You may not detain a client, but if you feel that the client is in physical danger when they return to their particular situation, you may report this information to the local police and the people whose names you obtained in your intake interview who are to be contacted in case of emergency. Of course, you have given ALL of your clients, ideally in writing, your procedures for dealing with situations where a person is a danger to themselves or others. See Chapter on Crisis and dealing with Suicide.

B. Danger to Others

If you believe a client is going to hurt someone when he/she leaves your office you need to call that person or the police to attempt to warn them of the danger. If they are HIV positive and actively engaging in unprotected sex and not revealing their medical status to their partner/s, there is general agreement that you may notify an identified partner, or the health department only if you have written medical confirmation of their medical status.

4. Confidentiality

The therapist's ethical standards require him/her to treat ALL communications, in any medium, as confidential. Even the fact that someone is a client is a private matter. When you meet the client on the street he/she must be the one to initiate acknowledgment that you know one another.

The client may permit the therapist to communicate with another, by signing a release form. A release is needed to communicate to other professionals, provide information to health insurance companies or any other outside party. If a client is using a Third Party Payer, and the company has told you they already have signed a release, it is good business practice to get one for yourself to keep in your file before releasing records. When you get the release signed, it is a good time to advise the client of your standards on confidentiality and that when the records leave your office (approved by them) you have no control over how they are used by their insurance carrier.

You need to plan what you will do in the case you go on vacation you need to provide for their needs and inform them about what they should do if you are unexpectedly not available.

Who has access to your records is also an issue. If you hire temporary office staff you must plan how clinical information will be safeguarded. Staff needs to be selected with care, trained regarding record handling and supervised regarding their performance.

When a client dies the responsibility for confidentiality does not expire. If parents ask for a copy of their dead adult child's clinical records you do not necessarily have to provide those records. It would be the determination of the court in your region as to whether they have a right to the records.

5. Privileged communications

Definition - an exchange of certain information between two persons in a relationship that requires trust and confidentiality.

Privileged communication is the legal affirmation of the ethical principle of confidentiality. It is the right of the client and means that he/she can invoke privilege to prohibit the testimony of the mental health professional if they are subpoenaed to testify in court. If invoked, the professional cannot be cited for contempt for refusing to testify about information obtained during treatment.

Communicating information about counseling interactions or materials can only occur upon the consent of the client, preferably in writing. Counselors may provide information to the public, subordinates, peers or supervisors if the content is general and in no way identifies the client. Information should be communicated in an unbiased, objective, factual manner.

Privilege is held by the patient, a guardian or conservator of the patient when they or the personal representative of the patient if the client is dead. Privilege can exist between psychological corporations, therapists, partnerships or other groups and their clients.

Guidelines for exceptions to privileged communication include the following:

A. The services of the therapist were sought to enable or aid anyone in committing or planning to commit a crime or to escape detention or apprehension after commission of a crime.

B. The therapist has reasonable cause to believe that the patient is a danger to self or others and disclosure of the communication is necessary to prevent the threatened danger.

C. The therapist was appointed by the Court to examine the client.

D. The proceeding was brought by or on behalf of the client to determine competency.

E. The patient is under age (refer to State definitions) and the therapist has reasonable cause to believe the patient has been the victim of a crime and that disclosure of the communication is in the best interests of the child.

F. The client waives the privilege.

G. The mental or emotional condition of the client is submitted into evidence as an issue in litigation.

Check with your individual State to determine what regulations apply to your professional practice. In some states you are required to testify in criminal actions, in others you are not. It is important that you know where you stand legally where you are practicing.

6. Laws relating to minors

It is your professional responsibility to know the definition of a minor in your state and the regulations that cover your professional relationship with them. A minor is a person who has not become emancipated by age, marriage, membership in the armed services, or petition of the courts.

Mental health professionals are constrained from treating minors without parental knowledge and consent. Therapists who choose not to notify parents must document their reasons for doing so and the child must be old enough to make an informed decision. When the minor is being treated without parental knowledge, the therapist holds the privilege in a legal proceeding. Of course, the minor is entitled to a completely confidential relationship with the therapist. If the parents are sending the child in for treatment and paying the bill; they may be able to compel the therapist to reveal the content of sessions, except in a legal proceeding. The responsible clinician will discuss the guidelines regarding confidentiality with both the parents and the minor at the start of treatment. Clinicians may offer to give the parent general information in the form of a progress report, that has been reviewed with the minor.

7. Court appearances

When subpoenaed by an attorney to be in court for a trial you are required to be there as a "fact" witness, not an "expert" witness. The "fact" witness is only required to provide hard information such as dates of treatment, fees paid, and clinical notes if released by the client or "certified" by the judge. An "expert" witness provides opinions. If, while appearing as a fact witness, an attorney asks for an opinion, you are not required to respond unless the attorney agrees to change your status, and pay a fee for your services, when the judge determines that an expert witness is necessary for a trial.

REPORTING

Recommended reporting guidelines:

1. When

When you believe there is a "clear and eminent danger to the client or others" you must take reasonable action or inform the responsible authorities. It is recommended you consult with other professionals when possible. The responsibility for the client's situation must be taken only after very careful consideration. The client should be given personal responsibility for their actions as soon as possible.

2. What

If you are called into a court proceeding or administrative hearing as a result of your report it is recommended you only provide the name, address, of a child or elder, nature and extent of the person's condition, and any other information required by the protective agencies involved including the information that led you to suspected danger or abuse.

3. Who

If you are licensed or credentialed most states consider you a "mandated" reporter. This means you must report any knowledge or reasonable suspicion of danger to self or others. Usually laws protect the person making the report from criminal or civil suit as long as the report was not made falsely. In some states not reporting danger or abuse is a misdemeanor.

4. Abuse

A. Child Abuse

When any one or more of the following acts are inflicted by another (even if the child "deserved it," or appears to be a willing participant) other than by accidental means:

1. Physical Abuse

- Sexual assault
- Lewd and lascivious acts
- Rape
- Incest
- Sodomy
- Oral copulation
- Penetration of a genital or anal opening
- Corporal punishment resulting in injury
- Abuse in out-of-home care
- A child showing injury, bruises from spanking should be reported
- Neglect
- Abandonment
- Emotional and verbal abuses are difficult to prove, it is the counselor's judgment call on this one.

2. Who to report to

Child protection agencies in your area. These may be the police, department of social services or a child protective agency. Usually a report to one covers all but you should check to see if you need to report to more than one agency.

3. What to report:

   Name and current location of child, nature and extent of the injury and any other information requested by the child protective agency.

4. What to consider for consultation

   a. How to assess and investigate for child abuse when you are the therapist for the child.

   b. Should you inform the family before or after the report?

   c. NEVER follow someone else's opinion about whether to report. IT MUST BE YOUR DECISION!

B. Spousal abuse

When you believe your client or the partner of your client is at risk for physical abuse, it is your responsibility to protect her/him from further injury. Of course, you have disclosed to him/her that you will report "danger to self or others" in your initial contact with the client. If your client is the person at risk and does not have a safe place to go, provide information about safe houses and shelters in the area. Make a call to any referral you provide so that you know about availability and that the timing of the departure from the dangerous situation is in the best interest of the client. You may not detain a client, but if you feel that the client will be in physical danger on returning to a particular situation, you may report this information to the local police. Remember to give ALL of your clients, preferably in writing, your procedures for dealing with situations where a person is a danger to themselves or others.

C. Elder abuse

When any one or more of the following acts are inflicted by another, other than accidental means:

- Physical Abuse
- Fiduciary Abuse
- Neglect
- Abandonment

Who To Report To:

- Elder care custodians.
- Medical practitioners.
- Nonmedical practitioners and employees of an elder protection agency.

You may report suspected cases of infliction of mental suffering on elders. Reports of suspected physical abuse should be made as soon as possible by telephone to an elder protection agency and in writing soon after. Check your particular state's regulations for guidelines.

D. Acquired Immune Deficiency Syndrome (AIDS)

There is not yet a universally accepted standard on reporting to a spouse or committed partner about the infection of your client. There does seem to be a trend granting clinicians immunity from legal action for any breach of confidentiality in these situations (Woody, 1997).

REFERRAL & CONSULTATION

Whenever you counsel a client, and at any time you believe you identify an issue that is beyond your scope of effective practice, YOU MUST attempt to make some type of referral. If a referral is not possible consult with a professional who has expertise in that area.

In cases of emergency referral, the client should have been advised at the beginning of treatment of the therapists availability. The clinician does not need to be available 24 hours a day but should make arrangements for client care when they are not available. If the client is not able to make emergency arrangements themselves the information should be made available to their family or caretakers.

RECORD KEEPING

Written records must be kept for clients to support the level of quality of care. These records must be clear and accurate. They must be secure and confidential. Records that are made immediately after a session are considered to be more accurate than if they are made some time later. Records are the property of the clinician. The client has a right to a copy of their records (and must pay for the copies) unless the clinician believes it is not in the best interest of the client. Parents have the right to a copy of their children's records. If the clinician believes it is not in the best interest of the child to release their records it then becomes the decision of the attorneys or the court to make that judgment. If the parent has a legal determination made, the clinician must hand over the records or suffer the punishment of the court.

When a counselor moves or retires they should place an ad in the local newspaper advising former clients as to the availability of their records. A counselor should make plans in their will or estate documents as to the disbursement or storage of their client records. Records may be transferred to another mental health professional or family member who will maintain the integrity of the records.

Clinical records are best kept in a prescribed format. The following system is generally accepted in the mental health field:

1. Clinical notes

All your clinical notes need to be kept in an orderly manner. Your notes need to be written in an objective and non-biased manner. One model that is used in the medical area is the SOAP method.

Subjective experience
Objective observations
Assessment of this information
Prognosis or recommendations made to the client.

Another model is a Problem Oriented method. This means that every note taken is coded to a specific problem that has been identified for this client. Interventions are coded to the problem they are meant to address. Include all interactions that take place in the counseling session that have to do with changes in the original *Professional Services Agreement*. You need to record all other exchanges of information, such as telephone calls or contacts that occur outside the office. Clinical records are the property of the client and must be given to them upon request unless you determine that it would be detrimental to the client's well-being to read them.

Clinical notes can include:

A. Test information

B. Correspondence

C. Audio tapes

D. Video tapes

E. Electronic data and communication

F. Telephone messages

G. Any other documents

All of these are considered to be private professional information and should not be available to anyone other than the client unless specified by National or State regulations.

It is a good idea to keep all financial records separate from your clinical notes.

2. Record storage

Storage and disposal of information by electronic or other means must maintain the confidentiality and privacy of the client.

Records should be under two locks. A person should have to go through two locking devices to have access to the records.

3. Availability to other professionals when you are on vacation and they are covering your clients

When a colleague is covering your professional practice and you are out of town and potentially not available for consultation, the colleague needs to have access to the client records you have asked them to be responsible for. If this is electronic information it might be on a disc that is secured under double lock, one lock can be a security code to open the data bank.

4. Abbreviations, initials and symbols

When you are making your clinical notes, either in your own office or in a job situation, never make any mark that is not readily understandable by others within your profession. Unknown marks can be misconstrued, and if you are working in a facility that is audited by a Medical or Hospital Accreditation Board, these notes will be marked unsatisfactory and create a problem for accreditation of the facility. If your notes are demanded in a legal action, any marks that are not professionally identifiable can cause you to be cited for unprofessional record keeping and your validity can be challengedand the reason for the change.

When you make an error or wish to change an entry do not erase or use "whiteout." Rather, draw a line through the material to be changed or removed and place the date and your initials on that line. Indicate in your new entry the corrected information which was deleted or changed and the reason for the change.

These are some examples of the acceptable abbreviations that have evolved over time:

ac	Before Meals
ADA	American Diabetic Association
A.D.L.	Activities of Daily Living
adm.	Admitted (admission)
AM	Morning
AMA	Against Medical Advice
amt.	Amount
appt.	Appointment
A.S.A.P.	As Soon As Possible
A.T.	Activity Therapy
AWOL	Absent Without Official Leave
BA	Baker Act
BFB	BioFeedBack
b.i.d.	Twice a Day
B/P	Blood Pressure
Bx	Behavior
c̄	with
CAT Scan	Computerized Axial Tomography
CBC	Complete Blood Count
CNS	Central Nervous System
c/o	Complains Of
Con't	Continued
COPD	Chronic Obstructive Pulmonary Disease
CVA	Cerebrovascular Accident
D/C	Discharge
D/c	Discontinued
DD	Date Dictated
Diff	Differential
DOB	Date Of Birth
Dr.	Doctor
DTs	Delirium Tremens
DS	Discharge Summary
Dx	Diagnosis

ECT	ElectroConvulsive Therapy
pt.	Patient
QA	Quality Assurance
q	Every
qd	Every Day
qh	Every Hour
qid	Four Times a Day
RN	Registered Nurse
R/O	Rule Out
R.O.	Reality Oriented
RT	Recreational Therapy
Rx	Take - Treatment - Prescription
s̄	Without
s	With
Soc.hx	Social History
Soc.Ser.	Social Service
stat	Immediately
TB	Tuberculosis
TTH	Twenty Three Hour
tid	Three Times a Day
TP	Treatment Plan
UR	Utilization Review
UKN	Unknown

PART II

Test Taking

Chapter 18 Test Taking
Chapter 19 MindMapping
Chapter 20 Personality Type
Chapter 21 Key Answers
Chapter 22 Scenarios
Chapter 23 Simulations

CHAPTER 18

Test Taking

You've got what it takes . . . to pass the National Clinical Mental Health Counselor Examination (NCMHCE). All you need to know is what areas you will be tested on, so you can learn or refresh your memory in each category to help you answer the test questions. We hope this chapter will help you to prepare and successfully pass your exam. Remember, the test has been prepared with the belief that it is a measure of how competent a therapist you are. Since there is such a wide range of beliefs of what a "good therapist" is, it can also be considered a test of how well you take this particular test. We at PTI want to provide you with the content materials you will need, and teach you how to think about the questions. We focus on content as well as process and believe that armed with these skills, you will successfully pass over this assessment challenge to a new exciting future in your chosen profession.

This chapter covers how to: Use **S**tudy groups, reposition your **A**ttitude so it supports success, create and stick to a study **P**lan, **P**ersonalize your content review and thinking process to **O**ptimize your performance, and how to manage the **S**tress and anxiety that is a natural reaction to this situation. Put them all together and you get **SAPOS,** the mantra we want you to chant whenever your inner fear tells you that anything less than success is an option.

THE WORKSHOP

If you have chosen to attend a test-preparation workshop, you will find that we give you an overview of each content area and let you know which areas to focus on. During the workshop, please hold your questions until we have covered the material and open the question and answer section. Often your questions will be answered during the presentation and if they are not, you will be able to ask better informed questions.

1. How to use the workshop

One of the benefits of attending the preparation workshop is having the opportunity to ask questions. During the question and answer periods, take full advantage of this opportunity.

We will be reviewing the content information to make certain you understand the concepts and suggest items to highlight that are important to remember. We do not expect you to remember all the information provided. We do want you to know what to study when you get home and make your study plan.

While you are at the workshop, use your free time to network with other test takers. Here is your opportunity to share your anxiety and concerns about the test with someone who understands how you feel. You are not alone.

2. Note taking

Some people retain information better if they take notes while the material is being presented. You will be given a new way to take notes called Mind Mapping (MM). Take a look at the Mind Mapping chapter for more information. We recommend you use our MM Model, and not worry about being tidy. If you decide to take notes on lined paper, we recommend that you draw a line from top to bottom on one side two inches in from the edge. Use this column to indicate topic areas or make notes about action items, books to refer to, or other information you do not want embedded and lost in your copious notes.

STUDY PLAN

As you go through each chapter, identify your study needs on the *Study Plan Guide* form. Make several copies of this form to update as you progress. It is important you create a Study Plan for yourself. You will notice at the top of the Study Plan Guide the headings: Area of Study; Saturation Level; Understanding Level; Priority; Start Date; Complete. Begin by entering the names of the study areas on the left. Next, identify each category's saturation level, and your understanding of the content material. (See below.) When you are through with this step, identify your priorities in order of importance, and schedule your study dates. (Begin with the Monthly Calendar form). When you complete an area to your satisfaction, mark it complete and move to the next priority.

1. Saturation

Spend more time on the sections that may be highly emphasized on the test. These have been determined by the saturation level of the sample scenarios or simulations provided by NBCC in their study booklet. You need to know the material in terms of content (What is the Rorschach Test?) and process (When would the Rorschach Test best be used in a treatment pian?).

A. How to Determine Saturation and Understanding

The term Saturation is being used to identify the level of importance a content area may hold on the test.

HS - High Saturation - Area is very highly emphasized throughout the test.

MS - Medium Saturation - Area is important in the test.

LS - Low Saturation - Area is used in the test at a low level.

High Saturation Content Areas
- Assessment
- DSM
- Outcomes
- Professional Practice
- Diagnosis & Treatment Planning

Medium Saturation Content Areas
- Counseling Theories
- Family Therapy
- Group Counseling
- Growth & Development
- Treatment Modalities
- Special Treatment Issues
- Substance Abuse
- Personality Theorists
- Lifestyle & Career Planning
- Psychopharm

Low Saturation Content Areas
- Statistics
- Research
- Prevention
- Organizational Consultation

B. Your Assessment of Your Understanding of the Knowledge Area

HU - High Understanding - Complete understanding of the subject area.
MU - Moderate Understanding - Moderate understanding of the subject area.
LU - Low Understanding - Not much understanding of the subject area.

C. Subjective

During the course, before information is presented, or before you review a chapter, indicate on your Study Plan Guide worksheet what you believe your understanding of the content area to be. At the end of the presentation or chapter, check your assessment and see if you want to make changes.

D. Objective

When you have had an opportunity to do some more case scenarios or simulations, check and see if your assessment of your understanding is the same, or needs to be revised. Proceed to the next step.

E. How to Study

Prioritize your study schedule with **1** being high priority and **3** being low priority:

1
HS/LU
MS/LU
HS/MU

2
MS/MU
LS/LU
LS/MU
3
HS/HU
MS/HU
LS/HU

2. Personalized study plan

A. Getting Started

During the workshop, or while reviewing the workbook, assess your understanding of each content area. Prioritize the topics based on the saturation level we recommend and your level of understanding. Create a schedule for yourself from today to the date of the test. Fill in your currently scheduled activities like work, sleep, etc. Pencil in all the other events and look at which ones can be rescheduled until after the test. You need a clear calendar from now until the test date. When in doubt, ask yourself, what is more important, passing this test or _____ . If you choose the event, ask yourself whose priority it is, yours, your partner's, your children's, your parents', your _____ . If it is your priority, fine, but if it is someone else's, schedule a time to talk to him/her and let them know how important passing this test is for you. See if you can reach a compromise and reschedule after the test.

B. Sample Study Schedule

The best time to study is generally in the morning or afternoon. After 5 PM and when you get home from work tend to be times when you are already saturated with the day's events. You may have trouble retaining information. Do not study material for more than 20 minutes at a time without a stretch break. Try to study before eating a large meal and certainly before consuming alcohol or other substances that alter your mental or emotional state. You want to study in the same state you will be taking the test in. This relates to state-specific information. You will remember information studied in the same state as you take the test in. It is also helpful to sit at a table to simulate the test conditions you will be operating under. Begin to design your study schedule. Start with a *Monthly Schedule* (see Forms). If this is all you need, great. If your schedule is more complex, go to a *Weekly Schedule*, and on to a *Daily Schedule* if needed. If you find you are not following your study schedule, for the next week track your activities on the *Time Log Form* to get a sense of what really is happening. As you study, and think of books, course notes or any other things that you believe would help your study process, make a note of the activity on the *Action* worksheet and review it at the end of each day. Schedule the activity on your *Study Plan* to make it happen. Finally, remember to reward yourself with "good stuff" when you stick to your schedule really well. Remember to take days off. We suggest taking a day off after 4 days of study. Your life needs a break and you don't want to begin to resent all the time you are spending away from "your life."

C. Detailed Sample Study Schedule

Let's say you have blocked off an entire day to study. Don't plan on sitting down at 9 AM and studying straight through. Break your reading or studying activities into 20 to 30 minute blocks. Between these blocks, exercise or perform some other physical activity for at least 10 minutes, preferably 15 to 20. Then, go back to your studying. Your schedule would look something like this:

0900-0920	Study
0920-0940	Walk around the block
0940-1000	Study
1000-1020	Ride the exercise bike
1040-1100	Study
1100-1120	Practice Relaxation exercises
1120-1140	Study
1140-1200	Prepare and eat light lunch
1200-1220	Study
1220-1240	Do eye exercises
1240-1300	Study

As you can see, between 9AM and 1PM (4 hours) you had 2 direct hours of study time and 2 hours of internal accommodation of the new material. This addresses both the content and process learning required for the test. In the interim periods, your mind is taking a break and integrating new material into your internal models. We recommend ending each session with a question of some sort, so while you are taking a break your mind is working and curiosity will bring you back to your study session.

3. Study skills and strategies

A. Goal Setting

Setting goals gives you benchmarks to use as the days pass. The first week after the workshop or after receiving your workbook, your goal might be to make your study plan. The best way to create goals is to start at the end and work backwards. Start by making copies of the *Monthly Calendar* form in this workbook, and enter the month and days. Mark the calendar with everything you have planned or committed to between now and the test date. Include your work and play schedule. Consider the time you have, the best times in terms of your energy level and enter your study times. Once you have an idea of how much time you currently have to study, ask yourself if this is enough. If it is not, then see what can be eliminated or postponed, or maybe it would be a good idea to take the test at the next regularly scheduled time.

On Friday, when you are remembering what took place that week, look at your study plan and personal goals and see what the reality is. Look at next week and make adjustments. If you find you are not studying like you believe you should, do some personal questioning about what is getting in the way. This is a good time to ask for help from your study group or others in your life to support your goals. Remember, you are not in this alone. It only feels like it sometimes.

Superstitious behavior and good luck charms? Yes, if they help.

4. Study groups

Make certain the group is close enough to you that you can get there with ease. Make an MBTI group profile so that if tasks are assigned you will be performing those tasks you are best suited for. For example, let an Intuitive create overviews of topics and Sensors make the detailed lists. Create a study schedule for the group and stick to it. Choose cases from the DSM Casebook and have each member make up question/s relating to Diagnosis, Treatment, Counseling Theories, Treatment Outcomes, Professional Practice, Assessment, etc.

If you find the group is "lazy" and not much is happening, give PTI a call and see if there is another group you can join. Use your networking skills and call some colleagues about starting another group. Tell your colleagues as gracefully as possible you are leaving as soon and gracefully as you can. Now is not the time to worry about hurting friends' feelings. Now is the time to study effectively.

CROSSWORD PUZZLES

Make copies of the crossword puzzles so you can do them more than once. Read the identified chapter for content and then work your puzzle. Use the index at the end of the workbook to look up key words only after you have spent some time "puzzling" over the answer. Not knowing an answer is a good indicator that it might be time to take a break and come back with a fresh perspective. Look at the answer sheet after 2 or 3 passes at the question. Don't torture yourself by trying to figure out the answer for hours. It's alright to look and come back later and redo the puzzle.

FOCUS AND ITS RELATIONSHIP TO YOUR PERSONALITY STYLE

You will need both a small and large perspective of all the information you will be studying. Be careful about getting caught in one perspective or the other. Your personality type has tendencies to prefer:

1. Perceptive type

Small perspective - Being able to define a term but not knowing how to apply it in the context of the exam.

2. Intuitive type

Large perspective - Being able to explain a theoretical counseling approach and not knowing what kind of interventions one would use in a particular case scenario.

ATTITUDES

A positive attitude is a tremendous asset. If you don't have one, find a self-affirmation tape and play it frequently. A negative attitude is a good technique to create negativity. Try using thought blocking techniques or use your negative thought as a trigger to chain a positive thought to. For example, if I feel fearful about taking this test, I can't help but remember when I was in the 7th grade and failed a test, then my next thought can be me being successful in some area. I can translate that feeling of success to a new image of me getting my test results with the word PASS on it. Here are some of the ways we all undermine ourselves.

1. Procrastination

Procrastination can keep you from studying until the last minute. If you find you are not able to create internal methods for studying, set up external situations that will prompt or force you to study. Procrastination is a good reason to join a study group. Let everyone know how you seem to be operating, and ask for help. Procrastination can also be an indicator of some issue that is getting in the way of you and your success. For example, taking this test can mean a life passage and a new way of perceiving yourself, and this can cause anxiety. There may be a part of you that is perfectly happy with the person who has not taken or passed this exam and finds everything in the world to do besides study. Your closet may be the tidiest it has ever been, since you would prefer to clean it rather than study. This is a good time to do some journal writing, talk to a friend or your therapist.

2. Denial

"The test is not important and I don't care if I fail." Then why are you reading this workbook, or why are you taking the test? If you choose to take the test for your professional future, then do the best job you can and see what happens.

REFRAMING ATTITUDES

This is not an examination of your personal value or worth. It is an examination on a particular body of knowledge, written by a group of people with a particular perspective. You are being tested on how well you know both of these things and have studied them. Try to keep your personal issues out of the process and just learn the material and answer in a way you believe is correct. Many people hinge their personal worth on their Pass or Fail grades. I have found that those few that did not pass the test are in fact very smart and quite competent therapists. On the other hand, they may not be very good at taking tests or have some event in their personal life overshadow the preparation process. Assume the best will happen - why feed the other option?

Use the behavioral chaining procedure to maintain a positive attitude. Use the negative mentation as a cue to add on a positive mentation. Denying the negative thought just adds to its power. Gently add on the positive and move on. When creating positive mentations, there are some good rules to follow. Create the new idea in the present and avoid negatives. For example, "I will not fail" contains negatives. "I am passing the test" is a positive. Some researchers say that the subconscious jumps over negatives like "not," so "I'm not a failure" translates to "I'm a failure." Since this is a possibility easily avoided, frame all your mentations in the present positive framework. "I am easily passing the exam." And so it is.

In terms of negative potholes you can get lost in, here are a few with their alternative paths.

1. Shoulding

This can be yours or anothers, both are equally useless. At the end of the week, when you discover you had planned 12 hours of study time and succeeded in 3, telling yourself you SHOULD have studied 12 hours, and next week have to study 21 to make up for your deficiency is guaranteed "study stress."

Solution - Treat yourself like a good parent would. Reward yourself for your three hours and build on that success next week. Notice the times you followed your study plan. Ask yourself what helped to make that successful. Use this new information to increase your study time next week. This takes us to blaming.

2. Blaming

Who do you blame for not studying for 12 hours? Look around-who is in sight? At my house when no one else is present, we have a dog and two cats to blame. It is amazing the things those critters pull off. As you can probably tell, we consider blaming to be as equally useless as shoulding, it gets you nowhere. You can also blame inanimate objects. If your closet didn't need to be reorganized, you would have been able to study.

Solution - When you find yourself blaming somebody, something or myself for anything, figure you are angry and scared and need some nurturing. Take out your good parent or teacher once again, and ask those hard questions about how not being responsible for what happened makes you feel better. Then, when the reason for blaming plops back in your lap, use the techniques mentioned in *shoulding solutions*. Look at the times you deviated from your plans and see if you can figure out what happened and why. Look at your successes and do the same. It could be that your study area faces your closet and each time you look up, you see something that needs straightening. It could be you have a sick cat and need help caring for it. It could be you are exhausted after taking care of the family, working, keeping house and now layering study time on top of that. Maybe you need to trim some things down or let others wait until you have successfully passed your test. We have yet to hear of anyone dying at the hands of gargantuan dust bunnies.

HOW TO USE THE WRITTEN STUDY MATERIAL

Large focus
- Crossword Puzzles
- Case Scenario and Simulation
- Mind Maps

Small focus
- Key Words
- Flash Cards

Content
- Index
- Key Words
- Key Responses

Process
- Case Scenarios and Simulations
- DSM Casebook

1. Retention

Look at the literature in terms of layers: format, core points, and first level specifics. Make an outline or Mind Map of this information. For example: Skim all the material in a chapter to find the central points and highlight them. Put all these items on your Mind Map/outline. Re-read the first section. Add a new level of detail to your Mind Map. Don't try to record every item of detail. The first three should be more than enough to grasp the main concepts. If you want more detail than this, make a set of flashcards.

2. Memory chains

One of the greatest memories ever documented belonged to Solomon Veniaminovich Sheresheveskii, a Russian newspaper reporter. He could reproduce word series and number sequences of any length and recall them upon request sixteen years later. You won't need to reach these heights but his techniques could help for the purposes of this test. Solomon used a mind technique of graphic association. For each word or concept he wanted to remember, he would create an inner graphic picture of it. For example, when you hear the word Red, you could think of a fire hydrant, or the word Freud, and visualize a popular picture of his face (remember the glasses). Now add to this his stages of development. Each one is a movie he is watching. Let your imagination be your only constriction in the images you create. The more bizarre they are, the better you will remember them.

THE EXAMINATION

1. Location and date and time

The test itself is usually given four times a year on a Saturday at a location in your region. If your test is being provided by a contracted testing company, contact them directly.

The test itself is usually four hours long, and you can leave at any time during the test when you have finished. If you need special accommodations of any kind, at least eight weeks before the test, contact your contracted test company and your state board to find out what kind of documentation you need to provide to substantiate your needs.

Special conditions include, but are not restricted to:
- Hearing impaired
- Visually impaired
- Physically challenged
- Any medical condition that requires special assistance
- Religious reasons

2. Process

A. Content vs. Process

You may have perfect recall of the course content information. You may be able to explain what the Rorschach test is comprised of, how it is scored, and the training needed to administer the test. This will serve you better if you know when it is appropriate to use during the process of treatment planning and implementation. The best way to improve your process orientation is to approach the test scenarios or simulations out of the DSM Casebooks in the following manner:

1. Read the entire case. If ideas come to you while you are reading, write them down but don't stop, keep reading. You can come back to them later.

2. Go back and look at your notes and think about your approach to this case, reviewing the content areas as you go (look at the table of contents or a case Mind Map of the content areas). Create a framework from your personal way of approaching this situation.

3. Applying this approach to the case scenarios:

   Look at the first question and identify the content area or areas it seems to be addressing. Ask yourself if you thought about this issue when you created your own diagnosis, assessment, treatment plan and prognosis. If not, now is the time. If you did, look at the answers and see if there is one there that fits. If the choices are not any that you would pick, step back and look at the terms and concepts that are being addressed. Ask yourself if you looked at these from a different value set, would any of these choices make sense? Eliminate the answers that you believe are wrong. See if any are left. Remember to consider what kind of question this is. Use your common sense. In a multiple choice test, if you really are at a loss, skip this question, and move on. Come back to it later after your subconscious has had time to digest all your considerations. In a simulation test, choose the answers you believe are appropriate. If you are in a later section and do not believe you have enough information to make a choice, re-visit previous sections.

4. Apply this approach to the case simulations:

   Read the first section carefully. Ask yourself if the section is an "information gathering" process or a "decision making" process. Proceed accordingly.

3. Scores

The response time is often six to eight weeks and reports are mailed to each candidate. Each state has cut off scores for pass/fail. Check with your Licensing Board for information about their cut off score.

EUSTRESS RATHER THAN DISTRESS

You need some healthy stress (Eustress) to motivate you to study and practice all of the above. When that stress becomes detrimental (distress), you need to address it immediately. Listen to your family and friends. If they notice you are grumpy or look "distressed," take some time to address your tension, and don't feel embarrassed about asking for help. EVERYBODY has some kind of anxiety over these kinds of examinations. Some just know how to handle it better than others and some have a better cover than others. The best solution is personal honesty and taking action when needed.

REDUCING ANXIETY

1. Desensitization

The goal of desensitization is to make you less sensitive to stimuli that triggers an anxiety response. To help your mind and body create a relaxed response, use the following practices. Of course, never follow any physical practice unless you are in good health and have the approval of your physician.

Exercise: Begin with a deep muscle relaxation. Get into a relaxed position, in a chair, and begin at the top of your head. Tense and relax every muscle group. Tense to a count of 5, relax to a count of 10. As you relax, repeat the affirmation "I am relaxed." Breathe abdominally as you are relaxing. Imagine the tension flowing down, out of your feet, and into the earth. Imagine that the relaxed area is filling with white, healing light. Either during or when you are finished, imagine yourself in a pleasant location where you can safely relax completely. This could be in the woods, the seashore, on a sailboat. The whole relaxation should take 15 to 30 minutes. When you are relaxed, create a trigger.

2. Triggers

Triggers are kinesthetic feelings that create a chained response. When you are very relaxed, find a place on your body you can put pressure on and push until you can clearly feel the pressure. As you press, focus on the feeling of relaxation. Hold this for 10 seconds. Reinforce your trigger each time you feel completely relaxed. The week before the test (you have now been creating your trigger for 2 weeks or more) begin to use your trigger when you are not feeling relaxed. When you notice you are stressed, press your relaxation trigger. Pause for a moment and notice how you are feeling more relaxed. Increase the feeling of relaxation as much as you can and move on.

3. Anxiety Scale

It will be helpful to know when your anxiety begins to increase and how you can be effective in making it decrease. The anxiety scale is a good tool to help increase personal awareness of anxiety. To begin, create a list numbered from 1 - 10 or 15. One is when you feel the least anxiety and 15 is when you feel the highest anxiety. Next to each number, describe at least two situations that are related to the test or the test preparation process. The example should help you recall the level of anxiety related to your experience.

Sample:

1. **Studying for the exam (Lowest Anxiety)**
2. **Evaluating a case scenario or simulation**
3. **Answering the questions of the case scenario or simulation**
4. **Preparing the day before the test**
5. **The morning of the test**

6. **Driving to the test**
7. **Waiting to register for the test**
8. **Sitting in the chair at the test table**
9. **Handing out the test**
10. **Taking the test (Highest Anxiety)**

Start with 1 and work your way to 10. Begin by relaxing and imagining the anxious situation. Notice where your anxiety and tension place themselves in your body. Use your tense/relax exercises and abdominal breathing to relax those muscles. Notice your tension changing to relaxation. Reinforce your trigger when you feel relaxed again. The next day, move on to situation 2.

PHYSICAL EXERCISES

Along with doing relaxation exercises, your body can benefit from some of the following activities. Remember to take it easy, you don't want a damaged body going to take the test. On the other hand, you do want a healthy body that will respond to questions and your guided relaxation exercises. Make sure your physician would not object to any of the following:

1. Yoga or Yoga-like stretching exercises

Acupressure or self-massage, especially around the head, neck and shoulders. You can use these while you are taking the test. Practice them now so they will come like second nature to you when you are under pressure.

2. Eye relaxation

Eye strain can be a real problem when you spend a lot of time reading. Do some eye stretches and then soften your eyes by looking far into the distance for a few seconds.

Eye Stretches:
Roll your eyes up and in circles in each direction. Rotate your eyes clockwise and counterclockwise. Soften your eyes and close them for a few minutes. Remember to breathe abdominally.

3. Walking

Now is not the time to begin a running program, but walking can be a gentle enough exercise to use to stay alert. Do not begin any form of exercise program if it is contraindicated by any physical condition or against the advice of your physician. You only need to walk for twelve minutes to get your circulation going and clear your mind. You might try taking walk breaks between study times.

PREPARING FOR THE BIG DAY

1. Week before

A. Begin to focus on Case Studies now. You need to apply your information to case scenarios and develop your treatment plans.

B. Drive by the exam site so you know where it is located.

2. Day before

A. DON'T

- Cram
- Test yourself

B. DO

- Eat a meal of carbohydrates that you eat often and know will sit well on your stomach.
- Exercise moderately.
- Make certain your transportation is arranged and verified.
- Put gas in the car.
- Engage in a pleasant light activity.
- Get a good night's sleep.
- Put all the items you want to take with you the next morning in a pile by the door (lucky rock, watch, purse, identifying papers, picture ID, watch, water).

3. Day of the exam

A. DO

- Set your alarm so you have plenty of time to prepare before you leave home.
- Have a friend call as back up.
- Exercise if that is normal for you.
- Eat a light nutritious meal.
- Wear comfortable clothes.
- Take a sweater in case it gets cold.
- Wear layers in case it gets hot.
- Arrive there at least 30 minutes early, or more if you need to find parking.
- During the test, take breaks. You will not be allowed to leave the room but you can stop and do some relaxation exercises, massage your shoulders or use acupressure points to clear tension. Remember to breathe.
- Listen to all the instructions carefully.
- Pace yourself. See how long it takes to answer the first ten questions and go from there.
- Use your triggers for relaxation whenever you notice tension or feel confused.

B. DON'T

- Get caught up in other folks' anxiety. If you need to stand alone, do it.
- Get upset if the exam starts late or has other glitches. Just take a deep breath and save your anxiety for another time.

4. Day after the exam

A. Relax

B. Enjoy

C. Create an obsession schedule if you find you are obsessing over the results.

GENERAL RECOMMENDATIONS

Read each case or simulation carefully and pay attention to details. Look at the clock and figure the quarter, half and three-quarter way marks. Look at the test and turn down the page corner at each of these benchmarks. Now you won't find yourself on the first simulation after four hours have elapsed. (Yes, I know you considered this as a possibility.)

Read all the instructions carefully. Those of you who scored high on the Intuitive scale of the MBTI will need to read them all at once and go back and do it again.

Remember, the devil is in the details.

KISS - Keep It Simple Sweetie

Try not to read more into a case than is there before you. Choose as many answers that seem appropriate, and move on.

Remember, it is helpful to think of the answers before looking at the answer choices.

Try to not be obsessive and review all your previous answers. The testing folks tell us that the most common reasons for wrong answers are selections that were added after the first choices are made. On the other hand, when you are finished, review your test to make certain you uncovered the answers you intended.

Onward!

STUDY PLAN GUIDE

Area of Study	Saturation Level	Understanding Level	Priority	Start Date	Complete

CHAPTER 19

MindMapping

USING ALL YOUR MENTAL TOOLS TO CREATE, ORGANIZE AND USE INFORMATION

Knowing how to use your mind is one of the last great frontiers. Aristotle believed that the mind was located in the stomach and heart area, luckily we know differently. As our knowledge of the brain has expanded, it has become common to model and compare it to computers. There are many similarities in their operations. Each receives information and processes it through one or many systems. Each has output. Computer's model bit by bit, logical and parallel processing systems and are becoming more complex. As computers become more sophisticated they operate at higher and higher speeds with more complexity.

Scientists realize that a bigger, faster, more complex computer will not create a model for the mind. There are things the brain can do that computers don't yet seem to do very well. Pattern recognition is one of the tasks the computer is just beginning to master. We humans and our minds do it with great ease.

MindMapping is the process of using your whole brain gathering information and using it to problem solve and organize your thinking. It is a more versatile visual form of outlining different from classic outlining, that starts at the top and works its way to the bottom.

MindMapping allows your mind to explore patterns and watch them develop out of random information. MindMapping promotes creativity, self analysis and provides a way to do individual and group brainstorming.

Mind maps help you organize your approach to case scenarios and simulations, extract needed information and make informed diagnostic and treatment planning decisions.

GETTING STARTED

1. In the center of a blank piece of paper draw a circle and write the theme of your mind map in the center. As ideas come to you, draw lines that connect to the original idea. Try to keep your ideas to one key word or phrase. Don't worry about the way it looks or whether anything you write is silly or unrelated. Turn your inner editor off! Write down everything that comes to you.

2. Look at the spokes coming off your circle and see if any of them are related to one another. Can you incorporate any of the ideas from one spoke into another?

3. Look at your clusters of information and see which ones have the most pieces attached to them. You may want to break them down into their own mindmaps.

4. Once you have sorted out your clusters, put them in a linear top down order and decide which ones have higher priorities than the others. Organize your information to fit whatever problem or idea you are dealing with.

Case Analysis

Use the MindMaps that follow as models to assess a case. Use these templates to analyze the cases as you review some chosen from the DSM Casebook. As you read each case, write information that applies to the lines radiating from the middle. When you are finished reading the case, ask yourself:

- What diagnosis would I give this case?
- What would my treatment goals be?
- What developmental issues are here?
- What is my initial treatment plan?
- What treatment approaches are indicated with this person or family?
- What treatment practices are contraindicated?
- What interventions would work best with this case?
- What are my client's strengths?
- What professional practice issues are identified?
- What assessments are called for?
- What referrals or consultations are indicated?
- What information do I need to answer any of the questions above?

MINDMAPPING BLANK

Diagnosis

Growth & Development

Personality & Social Development

Assessment

Treatment Planning

Counseling Theories

Treatment Modalities

Special Treatment Issues

Psychopharmacology

Prevention

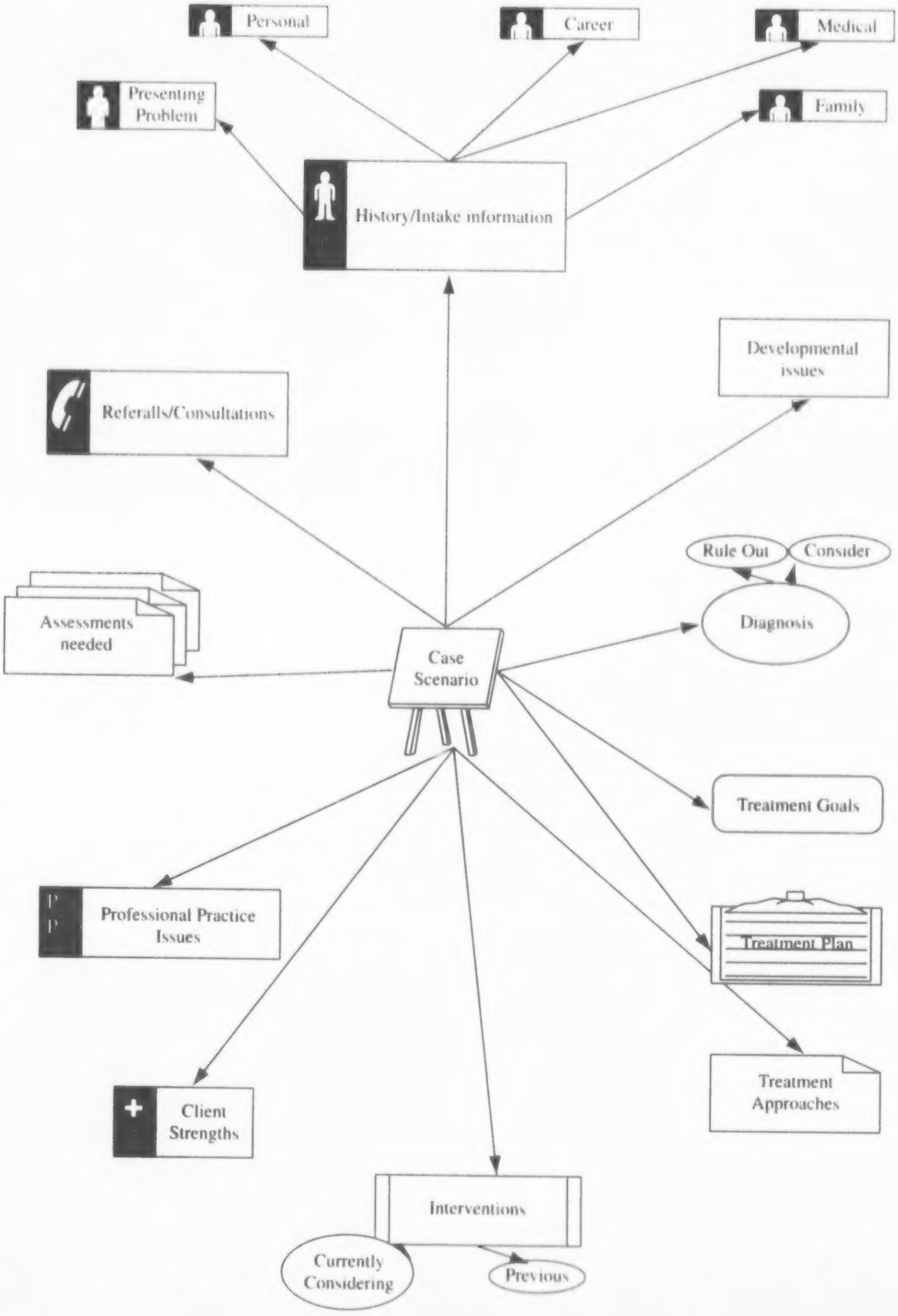
Career

Outcome Studies

Professional Practice

Case # __________

MINDMAPPING
CASE FORMULATION


Personal
Career
Medical
Presenting Problem
Family
History/Intake information
Developmental issues
Referalls/Consultations
Rule Out
Consider
Diagnosis
Assessments needed
Case Scenario
Treatment Goals
Professional Practice Issues
P
P
Treatment Plan
Treatment Approaches
Client Strengths
Interventions
Currently Considering
Previous

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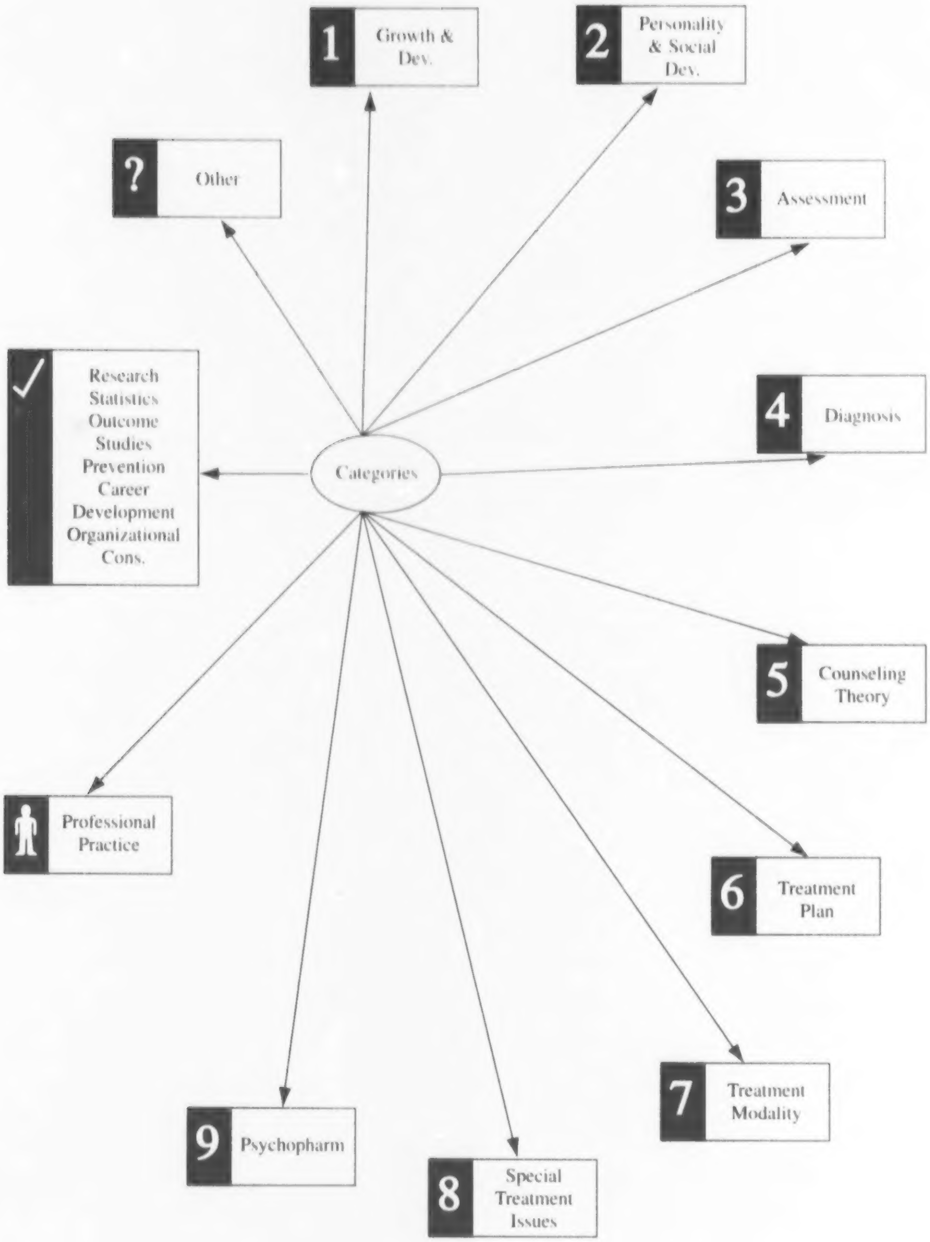
MINDMAPPING CONTENT AREAS


1 Growth & Dev.
2 Personality & Social Dev.
? Other
3 Assessment
✓ Research Statistics Outcome Studies Prevention Career Development Organizational Cons.
4 Diagnosis
Categories
5 Counseling Theory
Professional Practice
6 Treatment Plan
7 Treatment Modality
9 Psychopharm
8 Special Treatment Issues

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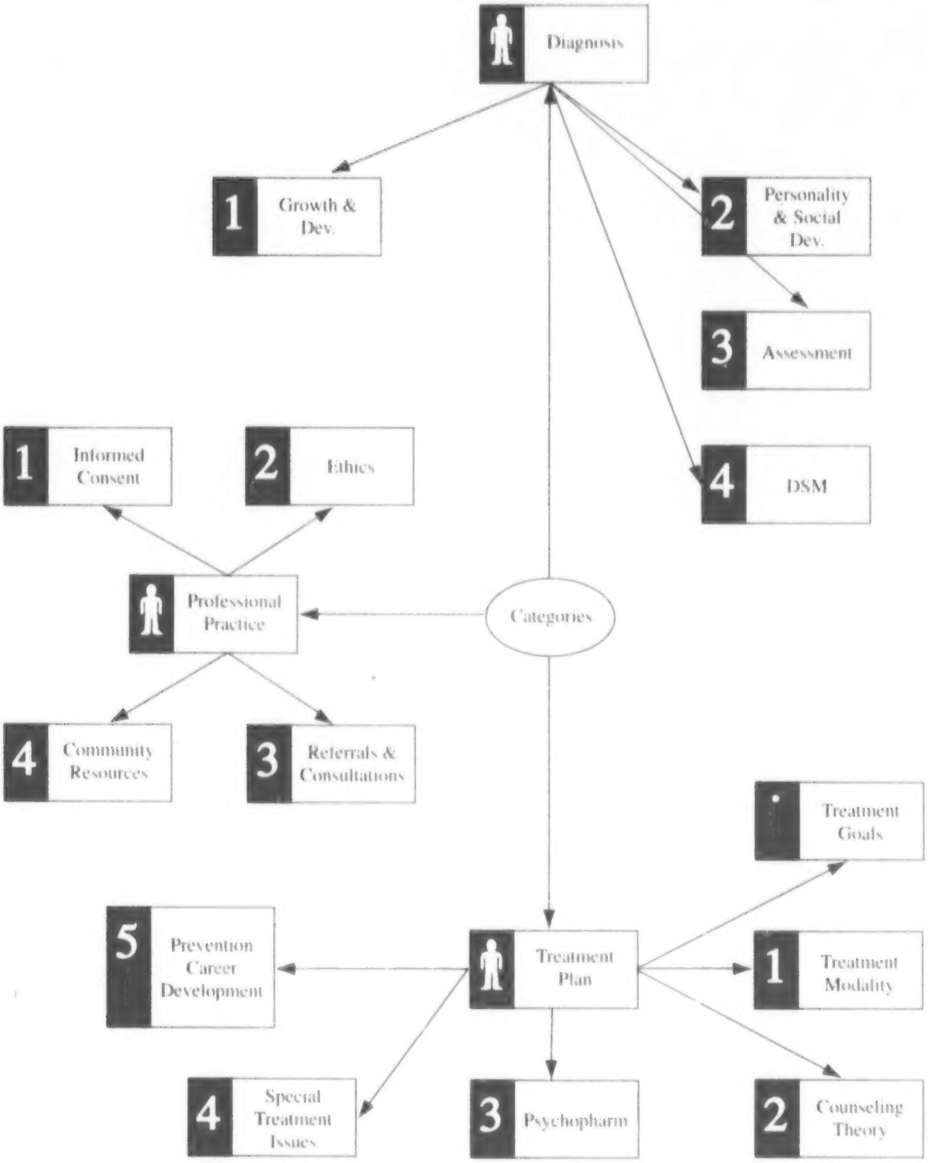
MINDMAPPING
APPROACHING A SCENARIO


Diagnosis
1 Growth & Dev.
2 Personality & Social Dev.
3 Assessment
4 DSM
1 Informed Consent
2 Ethics
Professional Practice
Categories
4 Community Resources
3 Referrals & Consultations
Treatment Goals
5 Prevention Career Development
Treatment Plan
1 Treatment Modality
4 Special Treatment Issues
3 Psychopharm
2 Counseling Theory

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CHAPTER 20

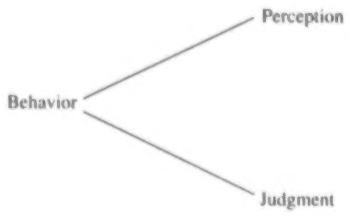
MBTI - Personality Type

The MBTI measures peoples differences. The instrument was developed in the 1920's by Katherine Briggs and her daughter Isabel Myers. The Myers-Briggs Type Indicator, commonly referred to as the MBTI, helps us to identify our preferences for taking in information, making decisions, and determining a preference for an outer orientation of action, contact with people or things, or an inner orientation of ideas, concepts, and abstractions.

The MBTI is a self-report instrument. It measures your responses to the items. You are the decision maker. The instrument is nonjudgmental. There is no right or wrong way to be, no correct or incorrect answers. When you take the MBTI, you choose some things and exclude others. The MBTI does not measure values or skills, but points out ways in which you can capitalize on your strengths.

People are different in fundamental ways yet there are similar drives that motivate us from within. The manner in which we pursue our needs and relate to others can be simplified, arranged into categories, and called preferences.

By identifying what your preferences are, and those of people in your life, you can begin to appreciate differences rather than judge others as wrong or bad.



An individual's behavior is a result of his or her preference for taking in information (perception) and preference for coming to conclusions (judgment). We all do both. Just as we have two hands, but prefer one over the other, we use both perception and judgment.

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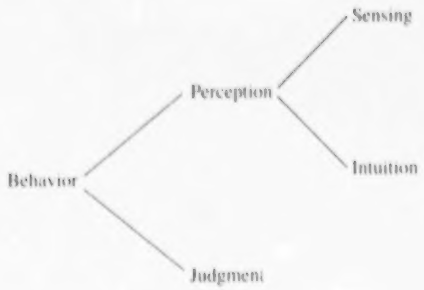
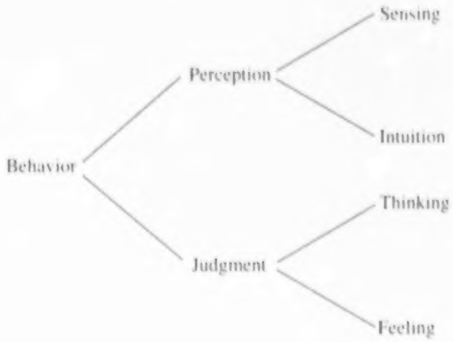


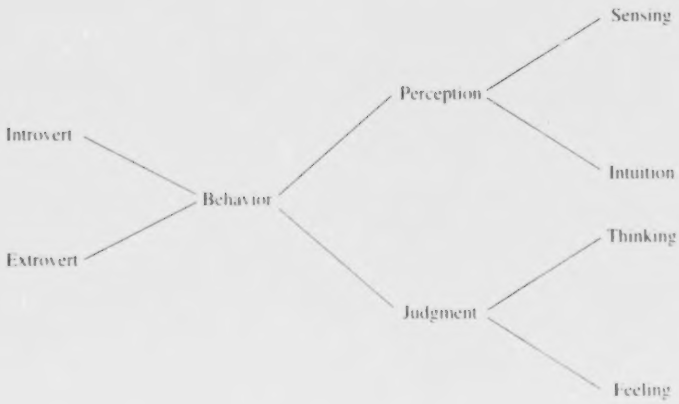
We also have a preference for how much time we spend taking in information and perceiving the world, and how much time we spend making decisions or judgments about that information. When it comes to taking in information, that is, when we perceive the world, we make another selection. Some of us choose to rely on our five senses: taste, touch, sight, smell, and hearing. We know something about the world because we've experienced it directly through our senses. We trust that kind of data. On the other hand some of us have a preference for taking in information that we glean through our sixth sense - our intuition, our "gut feeling," our hunches. We prefer to see things as they could be rather than as they are. We like possibilities and value information that comes to us through our intuition.

Looking at the model below we see choice points for sensing or intuition, thinking and feeling. We all use our senses and our intuition to take in information and think and feel about it. However, we will trust and rely on one approach and tend to prefer it over the other.



Just as there is a preference for how we take in information, there is also a preference for how we come to conclusions or judgments. When it comes to making a decision, some of us will prefer what is called our "thinking" function. We tend to decide things impersonally based on analysis and principle. People with a thinking preference place a premium on fairness.

Some of us will make decisions by valuing alternatives. This is called the "feeling" function. Those of us who have feeling as a preference tends to make decisions and judgments based on liking or disliking, on our values, or on the impact of the decision on people. People with a feeling preference place a premium on harmony. We all use both our thinking function and our feeling function to come to decisions, but again we have a preference for one over the other.



The final part of the theory concerns the concepts of introversion and extroversion. This preference tells us where we go to get energy. Introverts find energy in their inner world of ideas, concepts, and abstractions. They have a rich inner life and therefore seem to require less of the outside world.

Extroverts find energy in things and people in the world outside of themselves. They are pulled by this outer life of action and spend less time with thoughts and concepts. Remember, however, that we can be both extroverted and introverted - it's all a matter of preference.

Out of these choices come the sixteen personality types. Each personality type is identified by the first letter of each of the preferences (with the exception of intuition (N). The MBTI measures your preferences in each area. You end up with a score such as "ENTJ" that describes your set of preferences. Individuals that score in the middle of a range are given an "X".

To find out your type you can use the self-assessment in the book Please Understand Me (Kiersey, 1978), or contact the Consulting Psychologists Press (CPP) in Palo Alto, California.

HOW TO APPLY PREFERENCES TO HELP YOU PASS THE EXAM

1. EXTERNALS

Do well writing information down and re-reading information as they problem solve. They also enjoy study groups and talking about case scenarios.

2. INTERNALS

Need time to think, undisturbed, about a problem before they move on. Internals do well to read a case and then close their eyes and think about it before using any external information to problem solve.

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3. INTUITIVES

Intuitives naturally approach a case by looking at the big picture first. They will operate more accurately if they complete a MindMap before approaching the details of the case.

4. SENSORS

Sensors can use the MindMap template as a place to write down the details they notice as they read the case scenario. Sensor's prefer not to look at the big picture until they are sure they have covered all the details.

5. THINKERS

Thinkers approach a case from an analytic perspective first and address the feeling issues later. Thinkers need to remember to address the feeling aspects while formulating a diagnosis and treatment plan.

6. FEELERS

Feelers focus on the client's feelings. Their first goal will be to ease the client's anxiety. It is important for them to remember to formulate a diagnosis and treatment plan before they begin to work to relieve anxiety, unless the anxiety is a crisis situation.

7. JUDGERS

Judgers may rush to a conclusion before they have considered all the options of a case. Judgers need to remember to breathe and review a client or case before they move on to solve the problem. Judgers also need to review answers to make certain they have not skipped questions.

8. PERCEIVERS

Perceivers need to watch the time. They can get so caught up in the case and issues that time slips away from them before they can formulate a diagnosis and treatment plan.

CHAPTER 21

Key Answers

When you are sitting for the test it will be important that, when you see a particular Key Word, you have a set of prioritized responses to that issue. For example, if you see the word "eating disorder" in a case scenario, what initial action would you take as a competent clinician to insure the client's best treatment? If you are working off an assessment process that has as its highest priority the safety of the client, you would make certain that person had recently had a good physical since eating disorders can often result in physical problems. Once that is addressed, what would your next consideration be?

Here are a few Key Words and answers. If you disagree with some responses, do some research on standardized responses to see if a new approach has been identified as more effective. You might consider putting these on flash cards with the key word on one side and the responses on the other. Make up cards for all the high saturation content areas and the areas you believe you need more study in. Any ages that are mentioned are generalities and may vary between states.

ABUSE

1. Protect person from further abuse
    Is there a potential for immediate harm?

2. Inform of options and sources of support
    Have they had a medical exam? Do they need shelter? Is a criminal complaint in progress?

3. Abuser
    Teach appropriate ways to express anger
    What were the precipitating events
    Family rules
    Power structures
    How were they treated as a child?

4. Reporting
    Report within 24 hours, written 24–36 hours

5. Safety
    Separate parents from child while informing them of legal responsibility.

6. Signs
    Body bruises, brain damage, history of injuries

ADJUSTMENT DISORDER

1. Maladaptive reaction to stressor within 3 months

2. Impaired social or occupational functioning

ADOLESCENTS

1. Who holds the privilege (parent/guardian)

2. School records

3. Age appropriate behaviors

4. Parenting classes

5. Peer groups

6. Rational Emotive interventions

ALCOHOLISM

1. Take responsibility for self

2. Multigenerational analysis of alcohol use

3. Change in drinking behavior patterns?

4. Medical exam

5. Interrupt coalitions

6. Recovery similar to rebirth

ANOREXIA

1. Medical exam

2. Nutritional assessment

3. History

4. Work with expressing emotions

5. Increase self esteem

CHILDREN

1. Same as adolescents

2. Observations of children with family

3. Family sculpting

4. Play therapy/sand tray

5. Role playing

CO-ALCOHOLIC

Angry about alcoholics behavior

COUPLES

1. If they are under 21 wonder about why they're marrying now

2. Explore degree of differentiation from families of origin

3. Define expectations clearly

4. Myths of marriage and marriage contracts

5. If they are 21 and over, history of previous relationships/marriages

6. Communication patterns

CRISIS INTERVENTIONS

1. Catharsis assessment
    - Express feelings
    - Define emotional meaning
    - Mobilize or provide support
    - Realistic perspective with options or actions
    - History of crisis

2. Focusing/contracting
    - Coping behaviors
    - Agreement on core conflict or problem
    - Plan for resolution
    - Strategy

3. Intervention/resolution
    - R+ strengths of response
    - Response to issues, feelings, people
    - Define progress

4. Termination/integration
    - Transfer skills for future use
    - Community resources
    - Termination issues with therapist

DEPRESSION

1. Acknowledge & allow it

2. Grief work

3. Pattern recognition (journal work, creative arts, previous depression)

4. Substance abuse

5. Structure time use

6. What would happen if you were not depressed

DEVELOPMENTAL ISSUES

1. Piaget

2. Age appropriate behavior

DIVORCE

1. Parents
    - Limit setting with children
    - Mourning

2. Kids
    - Grieving
    - New/unusual behaviors due to fear and control issues

DOMESTIC VIOLENCE

1. Have victim removed to safe place
2. Obtain legal restraints
3. Counsel victim so they do not return to dangerous situation

DUTY TO WARN

1. Warn intended victim or someone who can tell them unless contraindicated
2. Call police

EATING DISORDERS

1. Medical exam
2. Nutritional assessment
3. Family dynamics

EMANCIPATION

1. Through marriage with consent of parents
2. Through legal process without consent of parents
3. Over states mandated age
4. Lives separately willingly
5. Manages own money
6. Enters military
7. Id card/marriage license

ETHNIC

1. Communication issues
2. Ask them for help with differences

3. Do you need to make a referral?

4. What are their cultural values?

5. Are you stereotyping?

FAMILIES

1. Is the communications system open/closed?

2. Family structure:
    Skew
    Schism
    Enmeshed
    Disengaged

3. How is discipline managed?
    Limit setting
    Expression of anger

4. Family roles/rules/myths

5. Family history for two generations
    Why they married
    What are their careers

6. Interventions
    Role playing, sculpting, what ifs, negotiation, active listening

GAY/LESBIAN ISSUES

1. Age appropriate issues

2. Systems issues

GRAVELY DISABLED

1. Mental & physical status

2. Physical exam

3. 72 hour mental evaluation

4. Hospitalization

GRIEF

1. DABDA - Denial, Anger, Bartering, Depression, Acceptance
2. For any major loss
3. Is there suicide potential?

INFORMED CONSENT

1. Explain counseling procedures and objectives. How often will they be seen?
2. Therapists role and qualifications
3. Discomforts and risks
4. Right to leave treatment
5. Confidentiality and reporting policies
6. Cost of therapy

INVOLUNTARY CONFINEMENT

1. Legal procedures
2. Safety issues

LEGAL ISSUES

1. Report to police or child protective agency

   Rape, intercourse with person under legal age, incest, sodomy, lewd acts, oral copulation, penetration by foreign object, physical injury, neglect

2. Under legal age get approval signed by parents

   Can see if abuse, incest, crime, pregnancy prevention gravely disabled, danger to self or others, drug or alcohol related problems

OBSESSIVE

1. Organic brain syndrome
2. Delerium

3. Dementia
4. Amnesia
5. Hallucinations
6. Delusions
7. Odd affect
8. Personality disorder
9. Drug/alcohol withdrawal

PRE-MARITAL

1. Why they are getting married
2. Differences in their families of origin
3. Marriage myths
4. Communication skills
5. Marriage expectations
6. Secondary deals

PRIVILEGE

1. Held by people over 18 (can be younger if state laws provide)
2. Privilege disappears when:
    - Written release
    - Danger to self or others
    - Child/elder abuse
    - Employee of the court
    - Under 16 and victim of a crime
    - A criminal case
    - To escape detection or apprehension
3. With minor and parents, negotiate what the family will be told about counseling sessions

REFERRALS

1. First gain trust
2. Obtain written release

RELIGION

1. Explore their belief system

RUNAWAY

1. Dependent on parent/child relationship
2. Foster placement
3. Child protective agency
4. See child alone & assess individual and relationship with parents, activities in the home
5. Check abuse, incest

SENIORS

1. Isolation
2. Abuse assessment
3. Medical problems
4. Financial problems
5. Grief work
6. OBD/status
7. Positive use of life
8. Validate feelings

SEXUALITY

1. Master & Johnson's sensate focus techniques

SINGLE PARENTS

1. Support groups
2. Coping skills

SUBSTANCE ABUSE

1. Signs of addiction
   - Alcohol
   - Drug
2. Length of use
3. Physiological addiction
4. Loss of control over use
5. Social/occupational complications
6. AA
7. Drugs - therapeutic communities, support groups

SUICIDE

1. Assess Lethality Plan, Means, Isolation
2. Privilege waived
3. Remove means
4. Plan for interventions by self and friends/family
5. Counseling
6. Management:
   - Contract to call or crisis line
   - Weapons removed
   - 72 hour hold? Voluntary or involuntary
   - High counseling frequency
   - Estimate telephone accessibility
   - Contact friends for support (lost privilege)
   - Contract

TESTING

1. Is test appropriate to counseling issues?
2. Are you qualified to administer test?
3. If not, refer to educational, school or clinical psychologist

VIOLENCE

1. Assess immediate potential for violence
2. Assess access to help or escape
3. Call Police or 911

CHAPTER 22

Scenarios

ELEVEN PHASE MODEL

Just as you follow a certain procedure to rebuild a carburetor or bake a cake, you follow a process to approach a new case. The phases listed below take you through the process, dealing with emergencies first and finally looking to the continued health of your client.

1. Phase one - red flags

A. Danger to self or others that must be dealt with immediately or possibly reported.

1. Suicide
2. Child abuse
3. Elder abuse

B. Spousal abuse

1. Assess if the client is at risk:
   Encourage client to remove his/herself from the dangerous situation. If they do not comply, provide information to help them reach safety if another event occurs.

C. Acute organic problem/s.

2. Phase two - appropriateness for individual therapy

A. Is the client currently working with another therapist?

B. Are they more appropriate for inpatient treatment?

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C. Are they currently substance abusing?

D. Is the identifying problem not within your scope of practice?

E. Assess client motivation

F. Assess ability to pay

G. Do they agree to informed consent?

3. Phase three - developing a connection

A. Develop a rapport

B. Find where the client is suffering - empathize

C. Address presenting problem/s

D. Establish your leadership and expertise

4. Phase four - initial assessment

A. Complete a mental status - include current physical

B. Has there been previous suicidal ideation or acting out?

C. Identify support systems:

1. Family
2. Friends
3. Work
4. Organizations

D. What are the client's ego-strengths?

E. What defenses are used?

F. Assess their level of insight:

1. None
2. Partial
3. Full

G. Assess the client's strengths

H. Identify the client's weaknesses

5. Phase five - screen and select problems

After the initial interview, what are the next steps?

A. Determine organic issues impact on clinical issues.

1. Medical disorders as a cause of psychiatric symptoms.
    a. Neurological
    b. Endocrinological
    c. Metabolic
        (1) Diabetes
        (2) Electrolyte imbalance
        (3) Vitamin deficiencies
    d. Cardiovascular
    e. Carcinoma
    f. Infectious diseases
    g. Systemic diseases
    h. Episodic diseases
        (1) Multiple sclerosis
        (2) Herpes simplex
        (3) Encephalitis
        (4) Pheochromocytoma (A chromaffin cell tumor producing hypertension by excreting epinephrine and norephinephrine.)
    i. Systemic lupus erythematosus

2. Psychiatric symptoms as indicators of undetected medical disorders

3. Current medications - are they being taken?

B. Identify problems that are undermining their quality of life

1. What are the primary symptoms?

2. What is the approximate duration of the problem?

3. How severe or pervasive is the problem?

4. Is there an identified precipitant for the symptoms?

6. Phase six - initial DSM diagnosis

What information do you need to formulate a provisional diagnosis?

A. Levels

1. Multiple

2. Hierarchical

3. Lifetime

B. Multi-axial Diagnosis

1. Axis I Clinical disorders Diagnosis

2. Axis II Personality disorders and mental retardation

    a. Personality disorders
        (1) Cluster A
            (a) Appear odd or eccentric
                - Paranoid
                - Schizoid
                - Schizotypal
        (2) Cluster B
            (a) Appear dramatic, emotional or erratic
                - Antisocial
                - Borderline
                - Histrionic
                - Narcissistic
        (3) Cluster C
            (a) Appear anxious or fearful
                - Passive aggressive
                - Obsessive compulsive
                - Dependent
                - Avoidance

3. Axis III General medical conditions

4. Axis IV Psychosocial and environmental problems

5. Axis V Global assessment of functioning

C. Provisional Diagnosis

1. Treatment history

    a. Medical
        (1) Acute
        (2) Chronic
        (3) Medication - Reactions to medication
        (4) Interventions
            (a) Surgery
            (b) Lifestyle change
    b. Previous diagnosis
    c. Premorbid personality
    d. Social history
    e. School
        (1) Grades
        (2) Disciplinary problems
        (3) Truancy
    f. Family history - Geneogram
    g. Assessments/Testing

7. Phase seven - verify or exclude diagnostic impressions

A. Follow up of preliminary impressions

B. Confirm history and its relationship to the initial DSM diagnosis

C. Exclude unlikely disorders

8. Phase eight - completion of data base

How will you know your client is making progress?

A. Test results

B. Baselines

1. Behavioral

2. Initial test results

C. Tracking measures

1. Self monitoring mechanisms

2. Assessments in the clinician's office

D. Outcome measures - Longitudinal measures taken after the termination of treatment.

9. Phase nine - treatment plan for each identified problem

A. Goal development for each problem

1. Strategic - Acute

2. Short term

   a. Behavioral
   b. Symptom relief

3. Long Term - Characterological change

B. Client contracts

1. Clear objectives

   a. Stated in behavioral, measurable language. Objectives should be listed on a problem sheet with a step by step longitudinal basis toward attaining the broad treatment goals. There should be at least two objectives for each problem.
   b. Target dates should be listed for each objective and ideally for each step.

C. Treatment contract

1. Goals
2. Effects
3. Termination

D. Referrals and consultations

E. Coordination to be done with:

1. Other professionals
2. Other treatment settings
3. Agencies
4. Schools
5. Any person or setting that is involved in the treatment plan

10. Phase ten - treatment modalities and approaches

A. Protocols for each diagnosis

B. Modalities matched to resources

1. Fiscal resources
2. Treatment setting variables
    a. Inpatient
    b. Outpatient

C. Modalities matched to goals

1. Symptom oriented
2. Short term, strategic approach
3. Insight oriented
    a. Psychodynamic
    b. Long term

11. Phase eleven - prognosis and maintenance

A. Tentative prognosis

1. Timelines for change - Resources available to support change
    a. Treatment resources
    b. Community resources
    c. Support systems
2. Predict treatment effects

B. Termination process - What referrals or recommendations would you make at termination?

C. Self management systems functionality

D. Outcomes measures and longitudinal follow-up

Use this process using the scenarios in this book or cases chosen from the DSM Casebook. Go over them with colleagues to see if there is anything you missed. It will soon become a process you can move through quickly.

MULTIPLE CHOICE STUDY CASES

These cases are to be used to assess your understanding of the exam content areas and your skills in working with counseling cases.

A. Question Structures

On multiple choice questions, there is a dominate question, or "stem," which may be a direct or open ended question. Then there are four choices. They are often divided into best answer, best overall answer, wrong or reverse answer, analogy or right answer. Here are some examples:

Best - All the answers are possible correct responses, but one is better than the others.

What would be the best choice for a toy for a three year old?
☐ 1. A toy truck
☐ 2. A doll
☐ 3. A safe toy
☐ 4. A sandbox

Correct answer - There is only *one answer* to this question.

Where would you find a quart of milk?
☐ 1. In an egg carton
☐ 2. In a toy chest
☐ 3. In the refrigerator
☐ 4. In the fireplace

Reverse type - You are requested to select the *reverse of the correct answer.*
Which of the following is not related to horses?
☐ 1. Horse shoes
☐ 2. Hay
☐ 3. Paint
☐ 4. Saddle

Analogy type - You will be asked to decide what *the relationship* is that exists between the first two parts of the question and then apply that relationship to the third and fourth parts included in the responses.
Painting your kitchen rather than hiring a contractor to remodel is the same as:
☐ 1. Destruction is to creation
☐ 2. Do it yourself is to delegating
☐ 3. Optimism is to pessimism
☐ 4. Play is to work

The answer is 2.

Ruth

Ruth S., a 32 year old female, senior executive secretary, was referred for treatment by a friend, following several seemingly unexplainable episodes of uncontrollable crying and trembling that caused her to leave work abruptly.

Ruth entered therapy in a very frightened, embarrassed and confused state. She was upset about her symptoms and did not understand them. She saw herself, prior to these symptoms, as basically functional, efficient and in control. During the interview she revealed that she had also "been finding herself" going to the lady's room and wanting to enclose herself and stay in one of the stalls for extended periods of time. Ruth was baffled and ashamed by these symptoms, but continued to reveal that she had become increasingly isolated over the last few months, staying home and watching TV, not seeing friends, not making social arrangements.

Further, she was finding it increasingly difficult to attend to ordinary life tasks, e.g., she "hated" the grocery store and shopping, and did not have the energy to clean or tidy her house. She was also having difficulty concentrating at work and at home. At home she could not keep track of her finances, unusual for her, and at work she was finding it difficult to focus on and complete tasks. Normally, a very competent and organized person, she was finding it hard to handle multiple tasks. She had become unfocused, confused and irritable at any interruption, or unscheduled or unanticipated request.

For the past month or so her sleep had been disrupted. She found it difficult to fall asleep, and her sleep has been interrupted by a series of bizarre, dimly remembered nightmares which awaken her. She then finds it difficult to return to sleep, and has been getting up to sleep on her living room couch.

Ruth reported having had a satisfying social life until about 9 months ago, when a long-term relationship she was in ended at her instigation. She reported feeling sad and disappointed that the relationship did not meet her expectations so that she could continue her involvement, but she felt she had handled the break-up and loss relatively well.

A family history revealed no history of depression or anxiety disorders in parents or grandparents. There was no evidence of drug or alcohol abuse. To her knowledge, no-one in her family had ever been in psychotherapy or taken any psychoactive medications.

Part of Ruth's distress was that she could not find a "cause" she could understand for her many symptoms. Continued exploration of her work and social life over the last several months revealed that Ruth was friendly with a colleague at work who was being harassed sexually by a supervisor. The friend had sought Ruth out for help and advice. They began meeting regularly to discuss a plan of action. Unfortunately, before they could take action, the friend was assaulted by the supervisor following a company social event. The assault was reported, the supervisor confronted and dismissed, but Ruth felt very guilty about not enabling her friend to take action sooner. She was also very worried about her friend's ability to recover from the assault.

Ruth felt some relief at her expression of feelings of guilt about the assault, and her worries about her friend. She also felt surprised to be discussing this and wanted to discount that her reaction to these events could have produced any of her symptoms. As her feelings about the assault on her friend continued to be explored (in a subsequent session) Ruth became increasingly agitated, rather than relieved. She began to experience the trembling, and wish to run and hide. She also began to cry and to connect this episode to an event at college, 13 years prior, when she was assaulted and raped by another student while on a date. She had never told anyone about this event, feeling enormously ashamed, humiliated, at fault, and confused. She felt she had to deal herself with "what happened" and "get on with my life."

QUESTIONS - RUTH

1. **Ruth wanted to discount that her reaction to her friend's assault could have produced her symptoms. This defense mechanism is called "Denial" and defense mechanisms are central to the theories of:**
   A. Carl Jung
   B. Fritz Perls
   C. Anna Freud and Heinz Hartman
   D. Horner

2. **The therapist can best view Ruth's inability to discuss this event with anyone to:**
   A. Her long standing patterns of denial
   B. The social context of the time in which date rape was not viewed as an assault
   C. The family's reaction to date rape at the time
   D. An operant response

3. **What would be the correct diagnosis for Ruth?**
   A. Sleep disturbance
   B. GAD Generalized Anxiety Disorder
   C. PTSD Post Traumatic Stress Disorder
   D. Adjustment disorder

4. **Ruth's therapist decided to refer her for a possible psychopharmacological evaluation. If the evaluation indicated an anxiety medication which of the following medications would fall in that category?**
   A. Prozac
   B. Haldol
   C. Xanax
   D. Ritalin

5. **Which counseling approach might be most appropriate to Ruth's situation?**
   A. Reality Therapy
   B. Supportive Insight
   C. Behavior Modification
   D. Desensitization

6. **Ruth's therapist also had been date raped as an adolescent. Considering the kinds of steps the therapist can take to ensure appropriate treatment for Ruth, which of the following would she not do?**
   A. Obtain clinical supervision
   B. Tell Ruth about her experience
   C. Consider the necessity of a referral to another therapist
   D. Be aware of countertransference issues

7. In order to make an appropriate diagnosis it would be important to:
A Refer Ruth for a physical exam
B. Refer Ruth for a substance abuse evaluation
C. Refer Ruth for a career counseling evaluation
D. None of the above

8. Given the behaviors described by Ruth over the last nine months, what important questions should be asked immediately in an intake interview?
A. Use of drugs and alcohol
B. Prior relationship history
C. Suicidal ideation
D. Family support for seeking psychotherapy

9. Of the following therapy choices, which would be the least useful for Ruth?
A. Individual therapy
B. Couples therapy
C. Focal Group Therapy
D. Psychopharmacology

10. At one point in the therapy Ruth considered a career change as a possible answer to her problems. Despite repeated attempts by her therapist to redirect her, she decided to use a Decision Making model in the exploration of Ruth's potential career change. Which theorist below is considered an expert in the Decision Making model?
A. Hoppock
B. Crites
C. Super
D. Roe

John

John, a 15 year old boy, came into the office with his mother. They tell you the school told them to bring him in because he bullies students and starts fights at the school, not stopping until he has hurt them. He seems to have little empathy for his classmates. He refuses to follow school rules or those of the home. His mother reports he occasionally expresses guilt about his behavior but she finds it difficult to know if he really feels bad or he just wants to keep from being punished. He can become hostile and threatening easily, particularly if he feels as if people are making fun of him or are mistreating him. He has come home drunk several times and has admitted to smoking marijuana "once or twice."

John and his friends have been arrested for smashing car windows and school vandalism as well as Breaking and Entering. His school truancy, which began in the 6th grade, continues and his academic grades are quite low. He has particular difficulty in the basic subjects of English and Math skills and refuses to participate in school clubs or sports activities, saying "Only babies and wimps do those stupid things." John's mother says that the difficulties with him began at around age 11 or 12, although he's always had trouble with school work.

John's father (who refused to come to the intake) is said to be a heavy drinker and never seems to have a good thing to say about anyone. He is very critical of his son and humiliates him at home and in public. The father is belligerent toward neighbors and feels that "this is a free country" and he has a right to do and say what he pleases.

John's mother is a quiet woman who seems intelligent but somewhat unsure about what to do. She describes herself as "trying to keep peace in the family" and making sure things don't get too volatile. She expresses feeling "caught in the middle between John and his father." She also admits to "being pushed around" by her husband "once or twice."

There is a 19 year old son in the home who has been arrested for "possession" a few times and is presently awaiting trial for "intention to distribute." His living at home makes things worse because he baits his father, seemingly for the fun of it and they have had numerous physical fights. The two boys get into a lot of fights, also, and have for years.

John sees no reason to come to counseling and says he's only there because he was threatened with being sent to a detention center if he didn't come. He says he used to be "a wimp" when he was young (his father called him that many times), but no one calls him that now or "they know what they'll get."

John speaks rapidly, smiling when he describes his activities and what he and his friends do. He justifies his activities by saying that "those people have 'shit' on me so many times. They deserve it." He describes years of feeling "made fun of" by various people.

QUESTIONS - JOHN

1. **The most important features of John's behavior are:**
   A. Lack of remorse and severity
   B. Fighting with his brother
   C. Truancy
   D. Substance use

2. **Often when working with children Family Therapy is indicated. What would be a contraindication for Family Therapy with John's family of origin?**
   A. John's brother's drug and alcohol history
   B. John's inability to follow rules
   C. Key family members are unavailable
   D. John's mother's passivity

3. **The counselor is doing research on adolescent treatment outcome issues. She is conducting a study on the effect of treatment on each group member. What is the dependent variable in this research?**
   A. Subsequent behavior
   B. Both are dependent variables
   C. Unclear with this information
   D. The treatment

4. **In considering John's difficulties it would be appropriate for his counselor to refer him for testing. The least appropriate test would be:**
   A. WISC-R
   B. MMPI
   C. Rohrsach
   D. Strong-Campbell

5. **John's therapist is considering other referral resources. It would be appropriate to have John evaluated for:**
   A. Substance Abuse
   B. Learning Disabilities
   C. Personality Problems
   D. All of the above

6. **If John's therapist decided that the initial therapeutic intervention for him was to be Group Therapy, which theoretical approach would be most appropriate?**
   A. Gestalt
   B. Reality Therapy
   C. Psychodrama
   D. Psychodynamic

7. **Johns absence of self control and sense of adequacy might indicate he is working on the developmental tasks of:**
   A. Rapprochement
   B. Latency
   C. Oedipal
   D. Preoperational

8. How would you diagnose John?
A. Conduct disorder
B. Adolescent Antisocial behavior
C. Adjustment disorder
D. Oppositional defiant disorder

9. John reveals to his therapist that he has been sharing his drugs with peers at school. What action should the therapist take?
A. Notify the police immediately
B. Call the school guidance counselor
C. Accompany John to school and open his locker
D. Talk with John about the danger involved with sharing his drugs with peers

10. The parenting style a clinician would be most likely to say contributed to John's difficulties would be:
A. Love & Autonomy
B. Love & Control
C. Hostility & Autonomy
D. Hostility & Control

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Mary

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Mary J. is a 29 year old, married women with two children, ages 5 and 7. She has worked as a legal secretary for 8 years, since graduating from her local Community College. Her husband, age 30, is a high school math and science teacher.

She was referred by a co-worker, who was also seeing this therapist, to whom she had confided her distress regarding her increasing sleeplessness, difficulties concentrating at work and feelings of worry and fear. Mary entered treatment reporting almost constant worry and rumination about various aspects of her life. Her worrying had become a daily focus for the past 7–8 months, and had been increasing in intensity over the last two months. She was verbal about her concerns and made appropriate eye contact. She spoke rapidly and intensely describing her concerns, often tapping her nails on the chair arm. She would also jiggle her leg, and left her chair to pace in the room several times during the initial session.

Mary's family history revealed no significant patterns of depression or substance abuse in either of her parents, both of whom are alive and well. Mary described her mother as a good homemaker, wife and mother, who was very attentive, concerned with her children's well-being, and who often worried about their health, friends, and success in school. An older brother also appears "nervous," but he may have a drinking problem. Upon some self-reflection, Mary described herself as a somewhat worried child, and that she was tense most of her life. She also described her father as a "tense, intense guy." There were some family conflicts between her parents around management of household chores and finances. Mary considered this normal. Mary reported that she engaged in no drug taking and was an occasional, social drinker.

Mary had also been in counseling one previous time while in college for help with anxiety over classwork and fears around exam taking. She saw the counselor 5–6 times and found it "somewhat" helpful. She was able to take her exams and graduate.

Mary met her husband in college. They married shortly after graduation, and had their children fairly soon thereafter. She reports having a generally good relationship with her husband, and enjoys her children. She has continued to work as a legal secretary and reports that juggling work and family responsibilities can be hard, but she is glad to be doing both.

She describes herself now worrying constantly about family finances, her health, her children's health and their school progress. The thoughts seem to focus on one worry for a time and then begin to shift to her other concerns. The worries are most troublesome when she begins to question her relationship with her husband in a generalized way as in "are they OK?" She has complained of excessive sweating, pain in her chest, and occasional faintness or light-headedness for over a period of several months, and recently suffered episodes of uncontrollable trembling and blurry vision. She has seen several medical practitioners because of these symptoms. There have been no physical illnesses or conditions found. She is finding that she is easily fatigued, even when she was getting enough sleep. In the past month her sleep has become markedly disturbed and she has difficulty getting to sleep and is easily awakened. When awakened, the worries go through her head, and she cannot return to sleep.

Usually an excellent worker, she has been experiencing difficulties at work. She is having increasing difficulty concentrating, and completing tasks in her usual efficient manner. She is feeling "wary and edgy" more and more of the time, and not enjoying her relationships with co-workers as much as she had been. Despite these concerns and complaints she reports she feels discouraged and not depressed. She still can enjoy some activities with family and friends, but she is worried about what is happening to her.

QUESTIONS - MARY

1. **You believe the best diagnosis for Mary would be:**
   A. Panic Disorder
   B. Generalized Anxiety Disorder
   C. Somatization Disorder
   D. Dysthymic Disorder

2. **The most important information the therapist needs before she begins therapy with Mary is:**
   A. Her most recent physical
   B. Her relationship with her husband
   C. Her college counseling records
   D. A mental status examination

3. **Given the nature of the referral, and Mary's reported symptoms, which would be the least important activity for Mary's therapist to initiate:**
   A. Obtain releases for medical information
   B. Provide Mary with informed consent regarding confidentiality
   C. Obtain a family geneogram
   D. Provide Mary with some cognitive thought stopping techniques

4. **Which of the following would be the most appropriate ancillary referral:**
   A. Medication Consult
   B. Substance Abuse Assessment
   C. Career Counseling
   D. Couples Counseling

5. **Mary presents a brief sketch of her family of origin dynamics. If Mary's therapist believes there would be value in gathering more information about the family system how would she approach this problem?**
   A. Ask Mary more questions about her family?
   B. Use Wiltwyck's family tasks
   C. Do a family of origin geneogram
   D. Do a structured family interview

6. **Given Mary's symptom picture a psychoanalytic explanation of her condition would focus on conflicts at which level of development?**
   A. Oral
   B. Anal
   C. Phallic
   D. Genital

7. **Given Mary's presenting symptoms, which is the least appropriate treatment for Mary at this time?**
   A. Group Therapy to discuss her concerns
   B. Psychopharmacological intervention
   C. Insight oriented individual therapy
   D. Relaxation techniques

8. **What would be the most appropriate response to Mary's questions about how her co-worker is apparently achieving great success with her problems through therapy?**
   A. Review the requirements of confidentiality
   B. Not reveal she counsels Mary's co-worker
   C. Reflect the question back to Mary about Mary's own concerns about her progress
   D. Tell Mary she doesn't want to discuss this particular issue

9. **Mary's therapist has had extensive training in cognitive therapy and she is most likely to use the skills and techniques of:**
   A. Joseph Wolpe
   B. Albert Ellis
   C. Aaron Beck
   D. David Rapaport

10. **Mary's complex of symptoms would be best treated by the following medication?**
    A. MAO inhibitors
    B. Anxiolytic
    C. Phenothiazines
    D. Barbiturates

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Billy

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Billy M. is a 43 year old white male who came into the office saying "I'm sleeping too much and I think it's not normal." He said that by "too much" he means continuously for nearly four to five days and nights. He says he "slips into sleeping" when he's upset about something then gradually "comes out of it" and goes on with his life. He feels that sometimes things get so overwhelming he just can't deal with them so he just goes to bed and sleeps. Sometimes in the four to five day sleep he awakens and is hungry so he gets up to eat something and then returns to bed. These episodes of sleeping occur every couple of months and have gone on for three years or so.

At the present time, Billy lives alone in a one bedroom apartment, but he lived with his mother for several years following his father's death seven years ago. His mother is in poor health and he worries a lot about her. He goes by her house daily and does odd jobs and chores for her although his youngest brother lives in the basement apartment of his mother's house. He says that being the oldest, he should take the responsibility for the care of his mother and anyway he has time since he is single and doesn't have family responsibilities like most of his other siblings.

Billy reports that he is the eldest of five children, three boys and two girls. All but his youngest brother and he are married and have families. He worries a lot that when his mother "passes on" the family will disintegrate and he will have no one in his life. He says his family "is all I have." He reports that he generally doesn't talk to his siblings about his problems because "they have their own families and problems to worry about." He reports little contact with his siblings, except his younger brother, since he lives in his mother's house and he sees him when he visits her. He does talk some to his mother, however, and he feels that she is his major support. Billy says that he felt close to his father who set high work standards for himself and his eldest son. Billy feels he never has been able to meet those standards, but that he should be able to do so. He is very upset when he thinks his father would expect more from him, particularly about work issues.

There are few things that Billy is interested in and he reports having no friends. He does do some photography, but doesn't consider himself a very good photographer. His family has always been very religious and he goes to church regularly, mostly because his mother expects him to. He states that he probably wouldn't do it on his own, although he considers himself a born-again Christian. He says he would miss it if he didn't go to church because that's his major source of contact with people even though he actually talks to very few of the parishioners.

Billy graduated from high school and worked for his father until they had an argument (about Billy not working hard enough) and he found a job elsewhere. He sometimes resents that his brother stayed working for his father and is now the owner of the family business and he, the oldest, couldn't "stick it out." His work history is one of getting a job and in two or three days feeling criticized by the boss or co-worker so he doesn't show up again because he believes they think he's not a good worker, or not a good person, or is a slow learner. Sometimes he doesn't even go back for his paycheck. If he has a job when he "slips into sleeping" he's so embarrassed when he recovers from his bout of sleeping that he "Just doesn't go back." He reports that one year he had about 45–50 jobs.

In his visit to the office, Billy presented as a nice looking man, wearing appropriate, clean clothing and obviously caring about his appearance. He describes himself as shy and feels he's not very interesting, so doesn't talk much. He's never had a girlfriend. He wishes he could find a girlfriend, but believes no woman would ever be interested in him and anyway, he says, he wouldn't know what to say to her. He states someone would have to be deeply religious like his mother before he would consider going out with her.

Billy reports that his father used to drink a lot and one of his brothers is "probably an alcoholic," but he, himself, rarely drinks at all and has never used drugs. He feels he would lose self-control if he used alcohol or drugs. He states that being in control is extremely important to him. That's why he would rather sleep when he feels overwhelmed than feel out of control of his life.

QUESTIONS - BILLY

1. **Billy needs several ancillary services. Which would be the most appropriate order?**
   A. 2 3 4 1
   B. 3 2 4 1
   C. 4 3 1 2
   D. 1 2 3 4

   1. Career
   2. Physical
   3. Psychopharm
   4. Personality Testing

2. **Billy's description of his symptoms and current activities would be best represented in the following diagnosis on Axis 1:**
   A. Dysthymia
   B. Major Depression
   C. Sleep Disorder NOS
   D. Social Phobia

3. **If Billy were to be diagnosed with a Axis II disorder you would choose?**
   A. Avoidant Personality Disorder
   B. Schizotypal
   C. Dependent Personality Disorder
   D. Schizoid

4. **Which of Billy's symptoms would raise a concern for immediate assessment?**
   A. 50 jobs in a year
   B. Slipping into sleep
   C. Alcohol/substance abuse
   D. Never having a girlfriend

5. **Billy's therapist is family systems oriented. She has identified Billy as the scapegoat in the family. Which family systems approach does this fit?**
   A. Bowen
   B. Satir
   C. Watzalwyk
   D. Haley

6. **Billy's therapist has referred him for a psychopharmacological consult. The least likely medication to be prescribed would be:**
   A. Tricyclics
   B. MAO Inhibitors
   C. Tetracyclics
   D. Anxiolytic

7. **Billy's therapist is currently involved in a sleep disturbance research project. Billy fits all the criteria for her control group. What is the therapist's primary obligation in considering Billy as a subject?**
   A. Informed consent
   B. Educating him of the possible consequences of the research methodologies
   C. Maintenance of the therapeutic relationship
   D. All of the above

8. **In planning Billy's treatment the therapist could include:**
   A. Individual psychotherapy
   B. Day treatment
   C. Partial Hospitalization
   D. All of the above

9. **Billy's insurance benefits have run out. Billy wants to continue therapy but since he has been moving from job to job, and sometimes doesn't pick up his paycheck, his finances are low. He has offered his therapist the opportunity to exchange service for service. He is especially good at yard work and would like to maintain the grounds around the office. This offer places Billy's therapist in the following dilemma:**
   A. Deciding how much grounds work is a fair exchange for each visit.
   B. Being concerned if Billy would really follow through on his end of the bargain.
   C. Wondering if Billy is physically able to do the yard work.
   D. None of the above

10. **Given Billy's personality and life problems, which type or types of therapeutic approaches would be contraindicated?**
   A. Cognitive
   B. Psychodrama
   C. Family Therapy
   D. Behavioral

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Washington

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Washington called for a counseling appointment for himself stating he was having trouble with his teenage daughter and needed some help since he was raising her on his own. He arrived at the office well dressed in a casually elegant style. He appeared very fastidious, and apparently in a good mood smiling and joking with the office staff. He spoke very carefully and deliberately, detailing events in his life using many psychological terms and references.

Washington described himself as an Engineer who was self-employed and an expert in his field. He talked about how he was sought after by several corporate headhunters but chose to remain in business for himself since he was being so successful. He continued talking about himself at some length, and revealed he was 52 years old, in excellent physical condition, divorced with three children, one daughter age 18 and two sons ages 23 and 28, all of whom lived with him in his condo overlooking the water. He had been divorced from his wife now for over 5 years.

When Washington spoke about the divorce he expressed bitterness and resentment toward his ex-wife for being continually insensitive to his needs. He was also angry with her now for not listening to his thoughts about how the children should be guided in their college and career choices.

He didn't say much about his family or origin, only that his dad was also an Engineer. He explained the reason his children were living with him, instead of his ex-wife, was because he was the better parent. His daughter had recently been arrested for drunk driving and he did not know what to do about it. He said he kept beer in the house but only drank one or two a day. He also was very angry about his youngest son whom he believed had been stealing tools from his garage. He could tell, he saw, because all his tools were organized and labeled, and each piece had a place. He also suspected his older son was gay. Again, Washington spoke about his work and how good he was at what he did.

Washington took some time explaining how he had been an expert witness recently and how his testimony was the deciding factor in the outcome of the trial. He also said he was very well read in the field of psychology and would like to discuss several topics with the therapist. He made repeated critical references to his ex-wife and admitted he did not "have much luck" with women since the divorce. His relationships tended to be brief and usually ended in an angry confrontation. He stated he was having a difficult time finding a woman who was well-read enough to sustain a long term relationship with.

He was at a loss about what was going on with his daughter and said they never talked. He said that their relationship consisted mostly of them letting each other know who was going to be where and when, what school he thought she should go to, and whether or not she could borrow his sportscar.

A second appointment was scheduled and at that next meeting Washington brought the therapist coffee and several books he was reading that he thought she might be interested in. He also suggested she join him and a friend of his for coffee to discuss some new ideas he had about the field of psychology.

QUESTIONS - WASHINGTON

1. **Given Washington's descriptions of himself, and using the therapist's observations of him in the office what would be your first description of his problems:**
   A. Obsessive-Compulsive Disorder
   B. Dual Diagnosis
   C. Narcissistic Personality Disorder
   D. All of the above

2. **What would be the first, most important point to attempt to clarify in the next few office visits?**
   A. A more accurate account of his drinking behaviors
   B. His daughter's drinking behaviors
   C. Frequency of contact with ex-wife and daughter
   D. The pervasiveness of his obsessive compulsive behaviors

3. **While Washington's therapist was at the library doing some research Washington appeared, came over to her, sat down, and began making a list of books and articles he thought would be relevant to the problems with his daughter. What should the therapist's response be to this situation?**
   A. Accept the list and promise Washington to check it out and discuss it in his sessions.
   B. Suggest that Washington read those books and discuss their issues as they relate to his daughter in his sessions.
   C. Say hello to Washington and leave the library.
   D. Tell Washington that she's interested that he's thinking about these issues, which can all be explored in future sessions.

4. **While assessing Washington's overall treatment needs, the therapist must consider the appropriateness of his career choice. Which rationale would be least important in making this assessment.**
   A. Given his obsessive compulsive habits he is well suited to organizing and managing a sole proprietor business.
   B. With Washington's daily use of alcohol his engineering vocation might be compromised due to poor judgment.
   C. Since it is so important to Washington that he be seen as an expert, being cast in role of "expert witness," makes his career choice egosyntonic.
   D. Washington had an excellent engineering education at a good college and is able to use his special skills on the job.

5. **Washington has identified many family problems and issues in his sessions. What would be a good first family systems intervention?**
   A. Bring the whole family into a session
   B. Interview the children individually to get their side of the story, which may shed more light on the real issues
   C. Construct a family Geneogram
   D. Bring Washington's ex-wife into a joint session to help identify the real problems

6. **What test could be used to verify Washington's diagnosis?**
   A. MMPI
   B. Bender Gestalt
   C. Wechsler
   D. Arthur Point scale

7. **Washington in his initial interview said he was in excellent physical condition, and he looks very healthy. He said he has a personal physician check him out every year and goes to see him for minor problems as they come up. What if any are the therapist's responsibilities in ruling out any medical problems that might impact his psychological treatment?**
   A. None - all the right questions have been asked and answered adequately
   B. The therapist should contact the physician to verify Washington's verbal reports
   C. The therapist should get everything in writing to obtain and verify Washington's reports
   D. The therapist only needs a copy of Washington's latest physical in his chart

8. **Theorists who might be interested in a social/developmental approach to Washington's personality development would be:**
   A. Schaefer and Anna Freud
   B. John Bolby and John Wolpe
   C. Erik Erickson and Albert Bandura
   D. Carl Jung and Abraham Maslow

9. **In creating Washington's treatment plan, the therapist must address many issues. Given Washington's presenting problem, and your initial assessment of the reason he has presented himself in your counseling office, what initial approach or intervention can you provide to help Washington begin a successful counseling experience?**
   A. Provide Washington with appropriate referrals for his daughter
   B. Improve the quality of his intimate relationships
   C. Help him understand how his drinking has an impact on his daughter and their relationship
   D. Help him acknowledge his own problems and how they affect those around him

10. **Washington's daughter told her mother about her arrest and that her father had contacted you to get some help for her. Washington's ex-wife then gave you a call and wanted to know what you were doing for her daughter. The best professional response would be:**
    A. Tell her what referrals you had given Washington for their daughter so she could follow up
    B. Say that you are not seeing Washington's daughter
    C. Invite the mother to come in and discuss her daughter's needs so you can be of more assistance
    D. None of the above

Beverly

Beverly S. is a 25 year old white adult female who came to therapy at the suggestion of a coworker because she was emotionally upset at work. She was upsetting customers at the beauty shop where she worked as a nail technician. Beverly said she was thinking of freelancing if she got fired from her current job. She was in the process of selling her home and moving to an inexpensive room, due to her divorce from her husband of seven years. Her soon to be ex-husband was a plumber. They had separated, she reported, because of his drug habit. She said he spent large amounts of money on cocaine and drank on top of that. She said when he was high he was abusive and she just couldn't take it anymore. Apparently he had been in and out of drug rehabilitation programs over the last two years but continued to use. Beverly was a pretty woman. She dressed in short tight skirts and tops with low-cut necklines. Beverly was good at her work but wanted to do something else. Each week she would decide she was perfect for a new profession or career. She had been at her current job for six months and had not been at the same job site for more than eight months in the last seven years. When she mentioned the name of the salon where she was currently working, the therapist realized it was the same one where she had her hair done monthly.

Beverly revealed how happy she was about the divorce. She talked about her new apartment and how beautiful it would be. Beverly had been married twice before and had two daughters from her first marriage who lived with their father. Beverly spoke rapidly and used many hand gestures as she talked. She said she had few friends and the few that she had were mostly men. She admitted she had been dating other men during the last year of the marriage and often slept with them. These relationships usually lasted for two or three dates, and often were one time events.

Beverly reported having days when she was so "bummed" she did not know what to do, so she would go visit a friend or go to a bar. She knew these "moods" would pass but when they were there she thought she would go crazy.

She spoke about the favorite thing in her life, her car. It was a sportscar that she loved to drive fast on mountain roads. She admitted she sometimes drove after she had been drinking with friends, or after drinking at home and leaving the house because she was mad at her husband.

She had one boyfriend who she talked about more than the others. He was often referred to as a wonderful guy but if he did something she thought was mean, she would complain about all his "awful" features.

Beverly revealed that she had been sexually molested by her father when she reached her teens. He would make her "strip naked," in Beverly's words, while he spanked her. This went on until she was sixteen and left home. Her mother knew about the "spankings" but did nothing to intervene. In fact, the mother would tell Beverly when she had been bad that she would tell her father when he got home so he could punish her. She said both of her parents were heavy drinkers since her first memories. Whenever the subject of her family came up in a session Beverly became highly agitated.

Beverly expressed a lot of anger about her father. He was dead and she kept saying she wanted to go to his grave and dance on it. Her mother was still alive, but Beverly refused to speak to her because of the way her mother had treated her.

QUESTIONS - BEVERLY

1. **Beverly had healthcare insurance through her workplace and used it to see her new therapist. Her insurance had a cap of $500 in Mental Health benefits per year. She was being charged $60 an hour with a co-payment of $10, and after 10 visits she no longer could use her medical benefits for therapy. What are the therapists' responsibilities regarding third party payments?**
   A. To fill out the paperwork accurately and in a timely manner
   B. To see her for as long as her benefits are authorized
   C. To manage her benefits as well as her treatment
   D. To see her for the co-pay only, after her benefits run out

2. **After her sixth visit Beverly revealed she was feeling down, as if nobody really cared for her. She wondered if therapy was really going to be helpful for her. She thought that maybe she should just take care of her own problems. How should the therapist approach this turn of events?**
   A. Assess for suicidal risk
   B. Encourage her to get in touch with her family for support
   C. Assess for depression
   D. Obtain the name of someone to contact in case of an emergency

3. **Beverly felt she was too active, possibly hyperactive and had seen a program on daytime television about Attention Deficit Disorder, which claimed that there was a wonderful medication that cured this problem. She had met many drug rehabilitation clinicians while going with her husband to his appointments and reported that she had been able to obtain some of the medications through one of them. What does the therapist do with this information?**
   A. Obtain the name of the person who gave her the medication
   B. Refer Beverly for a physical examination
   C. Refer Beverly to a Psychiatrist for a psychopharm evaluation
   D. Make a thorough clinical note

4. **What is the appropriate clinical diagnosis for Beverly?**
   A. Histrionic Personality Disorder
   B. Borderline Personality Disorder
   C. Anxiety Disorder
   D. Dual Diagnosis

5. **What ancillary referrals would be least appropriate for this client?**
   A. Complete physical
   B. Career consultation
   C. Support group for spouses of addicts
   D. Psychopharm evaluation

6. **Look at question #3. in what order should the following be done?**
   A. 2 3 1
   B. 3 2 1
   C. 1 2 3
   D. 2 1 3

1. Obtain a release to talk to the rehabilitation therapist she mentioned.
2. Talk with her about your concerns for her safety.
3. Write a report to the rehabilitation licensing board about the therapist who dispensed the medication.

7. Which of the following treatment modalities would be contraindicated?

A. Psychodrama
B. Gestalt
C. Family therapy
D. All of the above

8. What would be the first issue you would address in planning treatment for Beverly?

A. Deal with the underlying personality issues.
B. Address why she's having so much trouble in her life.
C. Help her explore the consequences of the sexual abuse by her father.
D. Discuss the issues concerning the divorce.

9. What stage of substance abuse is Beverly in?

A. Pre-abuse
B. Experimental Stage
C. Early Regular Use
D. Late Regular Use

10. Which developmental theory would be most helpful in understanding Beverly's problems?

A. Kolberg's theory of moral development
B. Maslow's theory of self actualization
C. Object Relations Theory
D. Piaget

Sue

Sue was referred by a colleague because of her particular symptoms. The initial therapist did not feel she had the special training needed to work with Sue's problems. She was dressed in a pink jogging suit and said she had just come from taking a long walk with her husband. Sue reported that she binged and purged frequently when she was alone, at least daily. She would either throw up or use laxatives. She was also afraid to go out of the house by herself, since she was afraid to talk to people and found herself hyperventilating and feeling faint when faced with either a stranger or someone she only knew superficially.

Sue was especially afraid of eating with others, even when her husband was with her, and absolutely refused to eat around her family of origin. This had been going on for 3 years now. Sue appeared to be very thin. When asked if she had missed any menses, she said no and that she would like to have a baby but was afraid to. She had done some reading about eating disorders and knew it was bad for her physically to throw up so often but she was unable to stop it.

Sue did not believe she was too thin but said her husband and family seemed to think she was. She wanted to please him but was terrified of putting on more weight. Her husband had recommended she see a therapist since he was afraid she would become ill if she lost any more weight. Sue wanted to know how she could stop focusing so much on food and gain enough weight to make her husband happy. She also wanted to feel better, less afraid, so she could have a baby.

Sue had grown up in an alcoholic family. Her father owned a bar and her mother drank at home. She reported her mother was physically abusive and often she had to protect her brothers and sisters from her anger. Sue had always been in charge of the family meals, seeing to it that all her siblings got enough to eat. Often there was not enough, and she would have to cut her food intake to make certain others could eat.

Her current food problems started when she married and moved in with her husband. She had started bingeing when he would go to work. She was afraid she would get fat and he would leave her so she began to take laxatives or throw up.

She would be cheery until he left for work, then she would get scared, moody and anxious. While he was gone for the day she often spent it in bed feeling "down." Just before he was due home she would clean herself up, put her cheery face back on and be ready for him at the door. Her husband did not know about these behaviors. When he was at home, she would turn on the shower if she needed to throw up.

QUESTIONS - SUE

1. **What is one of the first things you would have the client do?**
   - A. Start a food diary
   - B. Come in with her husband
   - C. Get a physical exam
   - D. Make an appointment with a nutritionist

2. **Sue will be a managed care client. What assessment tool would best be used for outcome tracking?**
   - A. WISC
   - B. Rohrsach
   - C. Strong Campbell
   - D. GAF

3. **In order to proceed appropriately with treatment you would need to have:**
   - A. A scale in your office
   - B. A signed release of information
   - C. Consent for treatment
   - D. Name of a person to contact in case of emergency

4. **What type of assessment would be most helpful for initial treatment planning?**
   - A. Personality Assessment
   - B. Family Assessment
   - C. Behavioral Assessment
   - D. Projective Test

5. **The client has asked if there is any type of medication that might help her with her problem.**
   - A. Appetite stimulant
   - B. Anti-depressant
   - C. Mood Stabilizer
   - D. MAO Inhibitor

6. **Given that Sue has problems in so many areas of daily life such as a strong history of distress in her family of origin; concerns about creating a family of her own; social isolation, food problems, which of the following would be least helpful in treating this case?**
   - A. Family Therapy
   - B. Insight Oriented
   - C. Cognitive-Behavioral
   - D. Rational Emotive

7. **In choosing a diagnosis, which would be most appropriate for Sue?**
   - A. Anorexia Nervosa
   - B. Bulimia Nervosa
   - C. Avoidant Personality Disorder
   - D. Social Phobia

8. How would you define the clinician's role in Sue's treatment?

A. Clinical team member
B. Primary clinician
C. Case manager
D. All of the above

9. Which treatment modalities need to be considered?

A. In-patient
B. Day-treatment
C. Group psychotherapy
D. All of the above

10. In terms of clarifying your diagnosis it is important to know?

A. Did fear of social situations begin in early childhood?
B. Is the purging behavior independent of or related to concerns about size and appearance?
C. What information her husband could give you?
D. Does she use laxatives?

Michele

Michele, nine years old, was referred for evaluation by her Guidance Counselor and 4th Grade teacher following several serious episodes of fighting, including hair pulling and punching, with classmates on the school playground. The school personnel also mentioned repeated "accidents" involving passage of feces during school activities. Her teachers reported that for the past several months (3–4) Michele would sometimes ask to use the lavatory, but not seem to arrive in time, and soil her clothing. At other times she would not ask to use the bathrooms, but would be found hiding in the clothes cubby area having soiled her clothing. Recently, piles of stool were found in the clothes cubbies at school.

Michele was also referred to her pediatrician who found no organic cause for the incontinence. Michele's mother reports that Michele was fully toilet trained for bowel control by 3.5 years of age, although mother thought the training was late, since Michele had been bladder trained by 12 months. Michele entered preschool at age three and had some difficulty in her first few months with the transition from home. Mother reports that Michele was a very verbal and alert child, active and needing a lot of attention. She seemed to have a hard time adjusting to the birth of her younger brother when she was aged 2.5 years. At that time she showed a brief period of reverting to one word baby-talk and requesting a bottle. This behavior disappeared after a few months. She seemed, then, to show interest and affection for her brother, mixed with some aggressive and hostile teasing.

Michele seems alternately distressed and nonchalant about the soiling. She becomes very upset, yelling and crying to "go away" and "leave her alone" if her mother or anyone else in the family mentions it. In school she has been found hiding and crying, but at other times seems to have an "oh well" attitude.

Lately, Michele has begun refusing to do her homework and chores at home, complaining about stomach aches and boredom. She has said that she has no friends at school; "no-one likes her and that she's stupid." Occasionally she comments that she's OK and that other girls are "stupid." In fact she has had a succession of "best friends" who seem to last a short while. She believes they don't like her because her nose is too short and she has "weird clothes." She won't discuss whether the other children at school know about her soiling. She says the recent fights at school have been because of being teased about her clothing and appearance. She has been talking about going to the mall and "grabbing some clothes."

Michele's mother reports increasing frustration with Michele. "She is hard to get along with." Michele gets upset easily if she doesn't get her way, and mother does not report ease with setting clear limits. Michele's father also reports that he is "easy-going" and doesn't like to see the kids get upset. The household rules are fairly ax, but when parental limits are finally pushed, mother tries to divert Michele's attention. When that doesn't work mother feels angry, then retreats while father yells. Michele's mother also has stated that she does actually prefer the younger brother, having herself come from a family of many sisters with no boys.

Michele also shows night-time fears and anxieties. For several years she has awakened in the night to ask to sleep in her parents room. She has nightmares about witches and is afraid of dying.

Michele related quickly to the interviewer and seemed initially very willing to engage in play and discussion.

QUESTIONS - MICHELE

1. **As the therapist considers all the possible counseling approaches, she wants to choose the one that would be in Michele's best interest. What would be most appropriate?**
   A. Psychoeducational work with parents regarding parenting
   B. Dealing with the marital schism
   C. Activity Group Therapy for Michele
   D. All of the above

2. **Michele's therapist would like to talk with her pediatrician, teachers and guidance counselor. The first thing she needs to do is:**
   A. Obtain a consent for treatment
   B. Obtain a signed release
   C. Request Michele's medical records
   D. See the entire family

3. **In Virginia Satir's theory of family games, Michele's family is playing which family game?**
   A. Lethal Game
   B. Growth Game
   C. Coalition Game
   D. Rescue Game

4. **In an attempt to understand Michele's problems, psychological testing is recommended. Which test would be the least appropriate for Michele:**
   A. Rohrsach
   B. House Tree Person
   C. CAT
   D. WPPSI

5. **Michele's pattern of symptomotology, fighting with peers, soiling, and nighttime fears can best be diagnosed as:**
   A. Enuresis
   B. Encopresis
   C. Narcolepsy
   D. Oppositional Defiant Disorder

6. **Michele's behavior at the birth of her younger brother can best be described by**
   A. Freud's concept of regression
   B. Burner's concept of Iconic encoding
   C. Piaget's concept of adaptation
   D. Freud's concept of the anal stage

7. **Michele's belief that the causes of her problems are her appearance, especially her clothes and the shape of her nose are examples of:**
   A. Pre-conventional morality
   B. Reaction formation
   C. Concrete thinking
   D. Oppositional Defiant Disorder

8. **Michele's mother is concerned that she has ADHD and that is what is causing all the problems. She has asked her pediatrician to prescribe medication. Which medication would be the most appropriate?**
   A. Ritalin
   B. Valium
   C. Phenobarbital
   D. None of the above

9. **The school counselor is doing a study on the effects of different kinds of therapies. She has divided the children who are in counseling into three groups, each group receiving a different counseling approach. The counseling approach used with Michele is considered the:**
   A. Discreet variable
   B. Continuous variable
   C. Dependent variable
   D. Independent variable

10. **The teacher's reports of children's behavior following 6 months of counseling is considered**
    A. Discreet variable
    B. Continuous variable
    C. Dependent variable
    D. Independent variable

Stella

Stella was referred to her therapist through her day program which is near the therapist's office. Stella generally walks to the office but often complains of shortness of breath when she arrives. She says she can walk about a block to the store near her home before returning, quite tired.

She complains to her therapist about many physical aches and pains. She says her heart hurts, her stomach hurts, as well as her leg where she had surgery several years ago. She often has headaches, her eyes hurt and a variety of other physical problems are the focus of much of Stella's talk in therapy. When she has her semi-annual check-up and she has a "clean bill of health", she does not believe her doctor's assessment. She says the doctor has prescribed a "calm pill" for her anxiousness. Stella likes to watch television programs that have doctors in them and writes down new diagnosis she learns from the TV. She makes lists of the complaints to tell her doctor next time she is to go for a checkup.

Stella lived in an institution for many years (she's 64 years old) but now lives in an Adult Foster Home. She lived with her mother until she was in her 20's when her mother died. She told her therapist that her sister had promised their mother she would "look after" Stella, so, of course, she would just stay with her sister. However, after a few years, her sister felt she was unable to care for Stella, so had her institutionalized. Stella is still very angry at her sister and feels abandoned by her family. Her sister now lives at the opposite side of the US and they see very little of each other, a fact Stella is very upset about. She also had a brother who died about five years ago. Her father died when she was young.

Although Stella has always been slow learning things, she is very deeply hurt when anyone suggests that she is mentally retarded. Recently she was on a bus when an adolescent referred to her as "that retarded lady." She became so upset that she had to be escorted off the bus and it was several days before she was able to be calmed down.

Stella went to school for a few years when she was young and her dream is to "graduate from high school" by getting her GED. She is being tutored in math and English at classes held at the local library. She proudly reports that she always gets her homework done when it is assigned.

Stella reports that she has been having some problems with other members of her day program. She says the staff feel she tries to take care of other people too much and the others don't like it. They sometimes yell at her and she yells back and feels they are ungrateful. She is quick to anger and feels others are picking on her. She is very sensitive to "fairness" and often feels that people take advantage of her, or will if she is not careful. If she perceives that she is being taken advantage of, she reacts quickly, and aggressively confronts the other person.

Stella reports feeling very lonely and "crying myself to sleep many nights," but she says she's not quite sure why she's crying. She has never had a boyfriend, but there are several men who are also in the day program with whom Stella is friendly. She talks to them and they talk to her and play "pool" and other games together. She feels like she's less lonely now and that it makes her life better.

Stella would like to live on her own. Not only does she want to be independent, but she often has difficulty with her Adult Care providers — feeling they are not very respectful of her. She has lived in several Adult Care homes. However, she is not really able to fully care for herself. She recognizes that she would put herself at risk, if she tried to live alone, because she is forgetful and doesn't actually know how to take care of a house. She resents the fact that others can live in an apartment, alone, and she cannot.

QUESTIONS - STELLA

1. **Because of the history of Stella's living situations and her age, her therapist needs to think about helpful interventions. What might be some good goals for Stella and her therapist to focus on?**
   A. Completing her GED
   B. Working with Stella and her day program to develop more supportive relationships
   C. Limiting the period of time she can complain about her physical problems
   D. All of the above

2. **Stella's therapist believes it would be a good idea to visit her at her day program. There are many activities that Stella is involved in that would give her possibly more information than she can gather during her sessions. Stella does not want her to come, but the head of the day program is begging her to help them in their work with her. How should Stella's therapist proceed?**
   A. Insist on your need as the therapist to see the program director.
   B. Make an appointment with the program director to discuss Stella's problems while Stella is at the doctor's office
   C. Consult an attorney regarding the therapist's options
   D. None of the above

3. **Stella's program has asked her therapist for a mental status update. A detailed description of Stella's history of cognitive development and cognitive style was reviewed. Which descriptor would be an accurate fit for Stella?**
   A. The presence of obsession
   B. Depersonalization and derealization
   C. Delusions
   D. Echolalia

4. **Stella's therapist wants to create a behavioral plan to reduce the frequency of her focus on her physical problems. The most helpful concepts of a behavioral program would be:**
   A. Systematic desensitization
   B. Creating an anxiety hierarchy
   C. Operant conditioning
   D. Stimulus generalization

5. **Stella's life has had many major changes. In terms of her mental problems what prevention strategies would have been helpful in decreasing Stella's current problems?**
   A. Developmental timing
   B. Identifying Stella as being at risk early in her life
   C. Getting Stella out of the institution earlier in her life
   D. All of the above

333

6. **Stella watches her therapist make notes during the session. During one session she asked her if she could see what she was writing. The therapist had just written down that she thought Stella was mentally retarded and was going to recommend some psychological testing. What shouldn't the therapist do regarding this request?**
   A. Hand over the pad she is writing on after she crosses out the information she thinks would bother Stella
   B. Discuss client rights with Stella
   C. Discuss the implications of seeing the notes with the client
   D. Explore why the client wants to see the notes

7. **Stella's therapist often searches for ways of working with her that Stella can be successful with. Given Stella's symptoms what would be the most successful treatment approach?**
   A. Cognitive - Behavioral
   B. Reality Therapy
   C. Stress Reduction Techniques
   D. Psychodynamic

8. **One of the reasons Stella has difficulty relating to men at her day treatment program is inadequate sex role development. The theory that would reflect the impact of her early institutionalization on sexual development would be:**
   A. Biological determinism
   B. Psychoanalytic theory
   C. Social Learning theory
   D. Cognitive development

9. **What is the most important factor that can predict a successful outcome in therapy?**
   A. The appropriateness of the treatment plan to the diagnosis
   B. Age of the client
   C. The therapeutic alliance
   D. All of the above

10. **In creating a diagnosis for Stella there are many issues to be considered. What would be the order of consideration for her problems?**
    A. 3 1 2 5 4
    B. 2 3 1 5 4
    C. 4 1 2 5 3
    D. 3 5 2 1 4

    1. Determine how long her problems have been in existence
    2. Determine how pervasive the disorder is
    3. Identify the major problems in Stella's life
    4. Verify the diagnosis by asking more questions
    5. Identify categories that share characteristics

Harris

Harris, a seventy year old retired business man was referred to an outpatient alcohol treatment program by his attending physician. He appeared well-dressed, attractive, articulate and clearly in the habit of giving orders. He had been married three times, and has been married to his third wife for twenty-five years. He had one child, a daughter by his first wife, with whom he was in occasional contact.

The eldest of 12 children, Harris, was born on a midwest farm. At age 14, he began to find ways to escape from farm chores by hiding behind the barn, smoking cigarettes and drinking whiskey. He reported that he left the farm in his early twenties and attended college, spending most of his weekends partying with friends, eating and drinking heavily.

World War II broke out right after he finished college and he enlisted in officer training, becoming a bomber navigator. His drinking increased with the stress of ever increasing numbers of bombing missions. He was shot down, rescued, and rewarded with an extended R&R which included extensive drinking.

When he returned to the states he continued the partying. At that time he was divorced by his first wife whom he had married at the outset of the war. They had an infant daughter. He quickly remarried, and his second wife was an active alcoholic. He was able to finish graduate school and start his own business. His second wife committed suicide seven years into the marriage. His third marriage followed quickly after the death of his second wife. His new wife was a woman twenty years his junior, who took care of "his every need."

At this time business stresses increased and there were hospitalizations for duodenal ulcers. He was treated with a bland diet, and placed on medication for high blood pressure. His physician also advised him to stop drinking, which he did for two weeks. He then began to drink his whiskey in milk. At this point his new wife started drinking with him. She became more critical of the disorganized behavior that resulted from his drinking, and started to take over more of the responsibilities of the business. He spent more time in his office alone, writing articles and seeing fewer and fewer people.

After several years he suffered a minor stroke and was hospitalized. His current physician insisted that he stop drinking. He followed the doctors' orders by eliminating whiskey and only drinking beer. This lasted for two to three weeks. He then returned to his previous drinking patterns. When he returned to the doctor's office for his annual physical, the doctor found his ulcer was recurring. The doctor asked him about his drinking. He confessed that he had returned to his old habits. The physician then referred him to an alcohol treatment program.

QUESTIONS - HARRIS

1. **Which defense mechanism seems to be prominent for Harris in his continued drinking?**
   A. Projection
   B. Denial
   C. Displacement
   D. Rationalization

2. **In what stage of treatment does Harris fall at the time of the referral?**
   A. Action
   B. Pre-Contemplation
   C. Contemplation
   D. Preparation

3. **In order to develop a complete assessment of Harris's condition his therapist would need all but which?**
   A. Interviews with significant others
   B. 16 PF or MMPI
   C. TAT
   D. CAGE

4. **What aspects of Harris's life would the therapist continue to evaluate frequently to assess level of risk for further self-injury?**
   A. 3&5
   B. 2&5
   C. 4&5
   D. 1&3

   1. Appearance at his office
   2. Status of his ulcers and blood pressure
   3. Continued withdrawal
   4. Denial of seriousness of drinking problem
   5. His continued drinking

5. **What kind of psychopharmacological intervention is most appropriate in alcoholism?**
   A. Benzodiazepenes
   B. Imipramine
   C. MAO inhibitors
   D. Prozac

6. **Harris's wife has been calling the therapist daily for information about "what is going on in the therapy," since "Harris wouldn't tell her anything." What should the therapist do?**
   A. Nothing
   B. Schedule a family session
   C. Talk with Harris about his feelings
   D. Suggest a referral to Harris's wife

7. **In order to plan effective treatment for Harris, his therapist needs to be familiar with outcome research for the treatment of alcoholism. This outcome research shows which of the following has good evidence of effectiveness:**
   A. AA
   B. Group therapies
   C. Hypnosis
   D. Self-control training

8. **Harris therapist has decided to use a family systems approach in dealing with Harris's problems. She has found in her work with Harris that he is emotionally cut off from family members. Which family systems theorist focuses on this issue?**
   A. Jay Haley
   B. Murray Bowen
   C. Virginia Satir
   D. Salvador Minuchin

9. **Given Harris's age what special issues does his therapist need to be aware of?**
   A. Sexuality
   B. Counter-transference issues regarding death & dying
   C. Meaning of life
   D. All of the above

10. **Which is the least appropriate goal for Harris's current treatment?**
    A. Maximize motivation for abstinence
    B. Improve Medical functioning
    C. Prevention of relapse
    D. Address spiritual issues

ANSWERS - RUTH

1. C - Freud and Hartman
2. B - She does not have a long standing pattern of denial, there is no familial information: an operant response does not exist, and the therapists needs to be aware of the societal context in which the experience occurred.
3. C - She meets all the criteria for PTSD; persistent avoidance of situations associated with the event; social isolation and withdrawal; persistent symptoms of increased arousal, i.e. difficulty sleeping, irritability difficulty concentrating
4. C - Xanax — Anti-anxiety
5. B - Supportive Insight therapy would provide validation of the event and allow an appropriate emotional release in a supportive environment.
6. B - When a therapist tells a client they have a similar traumatic experience, it has the potential for affecting the client's ability to be completely honest about their experience for many reasons. Sometimes viewed by counselors as a way of creating a bond with their client, the potential damage needs to be given higher value.
7. A - Given the cognitive changes and sleeping problems it is best to immediately rule out any organic causes or consequences to her actions in the last 9 months.
8. C - She has many behaviors that may point to suicidal ideation — withdrawal, shame isolation, sadness, guilt, assuming responsibility for others pain.
9. B - Couples therapy
10. C

ANSWERS - JOHN

1. A - Because it indicates the behaviors are egosyntonic.
2. C - When key family members are not available Family Therapy is contraindicated.
3. A - The independent variable affects the dependent variable so the independent variable is the treatment and the dependent variable is the behavior.
4. D - Strong Campbell since it is a career assessment tool.
5. D - All of the above because he presents problems in all of these areas.
6. B - So John could hear from his peers how they view his behavior and if it is age appropriate.
7. B - Latency because important relationships are school neighborhood and competence and the major conflict is competence Vs inferiority.
8. A - Conduct disorder — these behaviors are much stronger and more severe degree of behavior and pervasiveness does not show guilt and empathy.
9. D - The therapist is bound by confidentiality and does not have mandated responsibility regarding substance abuse but needs to work with John about his own substance use and the personal and legal ramifications in sharing his drugs. Duty to warn is very clear in that it must be a homicidal event.
10. C - Research has shown that style of parenting produces children that are angry and out of control, according to Baumrind.

ANSWERS - MARY

1. B - No single precipitant, multiple arenas of worry, pervasive, not easily controlled and interferes with functioning, specific symptoms are restlessness, edginess or muscle tension, easily fatigued difficulty concentrating irritability and sleep disturbance.
2. A - With her somatic complaints you must rule out any organic etiology.
3. C - In order to obtain the important medical information you need a release of information. Mary also needs to understand confidentiality before she reveals any personal information. When you look at how Mary's problems are impacting her daily life, her obsessive thoughts seem to be causing significant problems at work. These problems all need to be addressed before a family geneogram is sought.
4. A - Given her anxiety level, and the impact it is having on her work and quality of life, a psychopharm consult is called for. Anxiety conditions often respond well to anti-anxiety medication.
5. C - Mary is in individual therapy and based on the scenario, Mary's therapist does not know the accessibility of the family members or their willingness to participate. It has also not been determined that Family Therapy is the treatment of choice in Mary's current situation.
6. B - The symptoms of worry and rumination and physical agitation in a psychoanalytic framework correspond to symptoms of an obsessive compulsive personality type. This behavior or distress is postulated to result from conflicts at the anal level.
7. A - Refer to the section on Freud's developmental theories.
8. C - The scenario does not let you know whether it is mutually known to both of them that Mary's coworker is in therapy with Mary's therapist. Plus, Mary was informed about confidentiality in her first interview in the informed consent portion of the intake.
9. C - Refer to Counseling Theories.
10. B - Anti-anxiety medication.

ANSWERS - BILLY

1. A - They are ordered by the severity of symptoms, physical first, axis 1 next, strategic interventions for quality of life disturbances.
2. B - Major Depression — Because of the severity and pervasiveness of his symptoms. The isolation and sleeping have been going on for more than 3 years.
3. C - Billy has difficulty making everyday decisions without seeking excessive advice or reassurance from others; he has difficulty initiating or doing things on his own because of lack of self confidence in his judgment or abilities; he is unrealistically preoccupied about fears of being left and being able to take care of himself; and he has difficulty expressing disagreement with others because of fear of loss or approval.
4. B - You always rule out a possible organic etiology at the beginning before moving to other interventions.
5. B - Virginia Satir.
6. D - An anti-anxiety medication. The others address his depression.
7. C - Starting Billy in a research project would create a dual relationship which is a professional practice issue.
8. D - Billy has wide spread chronic problems which could benefit from a multi-modal approach and a highly structured environmental support system.
9. D - Exchanging or bartering for services is in conflict with ethical standards for counselors.
10. B - Psychodrama is contraindicated with someone who's ego defenses and personality structure are not solid enough to manage the demands of the treatment process.

ANSWERS - WASHINGTON

1. B - Individuals with drinking habits often don't self report correct quantity of drinking.
2. A - His alcohol could be endangering the life of himself or others, and often times persons understate their substance use.
3. D - Washington initially made the acknowledgment of knowing the therapist and the therapist then acknowledged his offerings and redirected further discussion between them to the next session. Because of the client's difficulty in acknowledging boundaries the therapist needs to be very cautious about any outside contacts with him.
4. D - Just because someone has a good education, does not mean he/she can do well in life. Psychological problems may interfere.
5. C - Geneogram since it is a good place to see familial patterns that have contributed to the family problems. It also offers Washington a framework to understand the family system and its dynamics.
6. A - The MMPI is commonly used to confirm a diagnosis of Personality Disorders.
7. C - The therapist must obtain first a release to obtain the records from the Physician and then a copy for her records.
8. A
9. C - This answer — addresses the presenting problem, Washington's lack of relationship with his daughter, his substance abuse, and his narcissistic injury. None of the other answers do this. (A) leaves his needs unanswered, (B) doesn't really address his presenting problem, which is his daughter, and (D) won't engage him and his needs.
10. D - All other answers breach the ethical guidelines for confidentiality.

ANSWERS - BEVERLY

1. C - To manage her benefits as well as her treatment (best answer).
2. A - Has the highest risk potential.
3. C - First — danger to self or others, general exam may, in fact, keep her on Ritalin.
4. B - Fits the description and Dual Diagnosis is not a formal clinical diagnosis it is a generic term referring to the coexistence of a major psychiatric illness and substance dependence and/or abuse.
5. B - Clinical issue not a vocational issue.
6. D
7. D
8. D - Because that is the presenting crisis and for a borderline you need to deal first with the presenting problem.
9. C - Her daily activities are not shaped around her drinking.
10. D - Piaget deals primarily with cognitive development.

ANSWERS - SUE

1. C - To assess her current physical status and rule out life threatening conditions.
2. D - Most standard measure at this point.
3. C - Before any treatment is begun this is needed.
4. C - To help determine danger to self.
5. B
6. D - Not oriented toward symptom removal and client had no insight into her emotional nature and cannot relate to its expression, developmental issues may be used later when emotional issues are mobilized.
7. A - Not Bulimia since she has body distortion problems which do not exclusively occur during episodes of anorexia nervosa.
8. A - Eating Disorders require multiple treatment modalities.
9. A - Because of her physical fragility.
10. B - To help discriminate between anorexia and bulimia.

ANSWERS - MICHELE

1. D - All If you just work with the child and do not correct the family system progress can be undermined.
2. A
3. D - One placates one blames and one is the distracter.
4. D - Only goes from 4–6 1/2 years of age.
5. B - 307.7 Encopresis without constipation and overflow incontinence Secondary Type.
6. A - Retreat to a safer period of time.
7. C - Concrete thinking.
8. D - There has been no diagnosis of ADHD.
9. D - The variable that changes or the experimenter manipulates.
10. C - Outcome is dependent upon treatment.

ANSWERS - STELLA

1. B
2. D
3. A
4. C
5. A - Identifies all the windows of opportunity in her life.
6. A
7. A - Connects anxiety to physical ailments.
8. C
9. D
10. A

ANSWERS - HARRIS

1. D
2. C - Acknowledged responsibility but minimal willingness to change.
3. C - Projective test that sheds little light on specific aspects of alcoholism.
4. B - Status of his ulcers, etc. & continued drinking.
5. A - See Chapter on Substance Abuse.
6. D - See Professional Practice.
7. D
8. B
9. D
10. C - He hasn't stopped drinking yet.

CHAPTER 23

Simulations

TEST FORMAT

The most recent revision of the National Clinical Mental Health Counseling Examination (NCMHCE) is made up of a series of case simulations. Each simulation is designed to cover the same competency areas as the multiple choice questions, as well as assess the clinician's problem solving abilities in terms of analyzing, diagnosing, and treating clinical problems. Each test is made up of 10 simulations which are divided into 5-8 sections. Each section is either an Information Gathering activity (IG) or a Decision Making activity (DM).

During the information gathering process you are supposed to obtain enough information to answer the question that has been posed in that section. When you believe you have enough information, you stop selecting "responses" in that section. You lose points for selecting "responses" that are deemed not appropriate, or not relevant to the question that has been posed. For example a correct response might give you 2 points, while another incorrect choice would subtract 2 points from your overall score.

In the decision making section you are asked to make clinical judgments or decisions about treatment planning, testing, diagnosing or other areas of decision making the clinician faces in any case. There are two forms in the decision making section. One has only one answer that is correct, and others have multiple selections that are correct. These also have answers which, when selected, could result in a deduction of points from your overall score.

The NCMHCE test booklet is printed so that information only becomes visible when a "latent image" pen is brushed over the "shaded" areas. When you see an asterisk (*) you know you have reached the end of the information in that box. Some boxes will direct you to other sections of the test, or advise you that you have reached the "end of the problem" and instruct you to proceed to another area.

It is very important that you do not uncover responses you do not think answer the question you have been asked.

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Each "simulation" begins with a brief paragraph giving you the setting and initial information about your case. Each simulation contains several sections, A through G. The responses in the following example, with a shading around them, cannot be seen in the booklet. You only see this information once you have passed the latent image pen over the shaded box. We have provided a sample of an information gathering and decision making section for you.

In the simulations provided in this book, reveal in sequence, the information pertaining to each response option that you choose. When you have completed a simulation, go to the corresponding score sheet and add up your score. Fill in the box in each section with our score and tally all your scores in the section "IG and DM" scores for your total.

The abbreviations on the score sheets stand for:

IG - Information Gathering
DM - Decision Making
MPL - Minimum Passing Level
MAX - Maximum score possible

SAMPLE SIMULATION HARRIS

Harris, a seventy year old retired business man was referred to you from an outpatient alcohol treatment program. He appears well dressed, attractive, articulate and clearly in the habit of giving orders. He has been married three times, and has been married to his third and current wife for twenty-five years. He recently suffered a minor stroke is concerned that his drinking may increase the likelihood of another more severe stroke.

SECTION A HARRIS

During your intake session what would you need to ascertain to move to the next stage of treatment? *Select as many as you consider indicated in this section.*

A-1	Release of information for the Physician	A-1	**Done***
A-2	Obtain a CAGE	A-2	**Reveals he is in the later stages of alcoholism***
A-3	Ask to meet with his wife	A-3	**Done***
A-4	Determine his occupation	A-4	**Not relevant***
A-5	Previous treatment	A-5	**None***
	When you have completed this section uncover response A-6	A-6	**Go to section B.***

You will now visit more sections where you gather information about the case. In the final section you are asked to make some decisions.

SECTION B HARRIS

At the last session what referral would you make?
Select only one.

B-1	Alcoholics Anonymous	B-1	**End of the problem. Go to Simulation 9***
B-2	Family counseling	B-2	**End of the problem. Go to Simulation 9***
B-3	Those requested by the client	B-3	**End of the problem. Go to Simulation 9***
B-4	Outpatient support group	B-4	**End of the problem. Go to Simulation 9***
B-5	Vocational program	B-5	**End of the problem. Go to Simulation 9***

SAMPLE SCORING SHEET

SECTION A
(Information Gathering)

Option	Score
A-1	+2
A-2	+2
A-3	+1
A-4	−2
A-5	−2

IG MPL/MAX for Section A
MPL: 3 MAX: 5

Your section A score:

SECTION B
(Decision Making)

Option	Score
B-1	+2
B-2	−1
B-3	−2
B-4	+1
B-5	−1

DM MPL/MAX for Section B
MPL: 2 MAX: 3

Your section B score:

SECTION C
(Decision Making)

Option	Score
C-1	−2
C-2	−1
C-3	+2
C-4	−2

DM MPL/MAX for Section C
MPL: 2 MAX: 2

Your section C score:

SECTION D
(Information Gathering)

Option	Score
D-1	−2
D-2	+1
D-3	−1
D-4	+2
D-5	−2

DM MPL/MAX for Section D
MPL: 2 MAX: 3

Your section D score:

IG and DM Scores

	IG		DM
A		B	
D		C	
Your Total			

IG	DM
MPL: 5	MPL: 4
MAX: 8	MAX: 5

(adapted from NBCC 1997)

Simulation 1 Michelle

You are a mental health counselor in a group private practice. Michelle, nine years old, was referred for an evaluation by her Guidance Counselor and 4th Grade teacher following several serious episodes of fighting including hair pulling and punching, with classmates on the school playground. The school personnel also mentioned repeated "accidents" involving passage of feces during school activities.

Section A Michelle

During the first session what information would be important to assess in order to formulate a provisional DSM IV diagnosis? *Select as many as you consider indicated in this Section.*

A-1.	What other school activities is Michelle involved in?	A-1	
A-2.	Family relationships	A-2	
A-3.	What is Michelle's relationship like with her teacher?	A-3	
A-4.	Peer relationships	A-4	
A-5.	Religious/ethnic background	A-5	
A-6.	Developmental history	A-6	
A-7.	Early play activities	A-7	
A-8.	Language development	A-8	
A-9.	Physical exam	A-9	
A-10.	History of symptoms	A-10	
A-11.	Family history	A-11	
	When you have completed your selections in this section, uncover response A-12	A-12	

Section B Michelle

Michelle's treatment plan needs to address the following issues.

Select as many as you consider indicated in this Section.

B-1	Low self esteem	B-1	
B-2	Academic achievement	B-2	
B-3	Autonomy	B-3	
B-4	Dependency	B-4	
B-5	Social skills	B-5	
B-6	Abandonment	B-6	
B-7	Self-image	B-7	
When you have completed your selections in this section, uncover B-8		B8	

Section C Michelle

What special treatment interventions would apply to Michelle?

Choose only one.

C-1	Cognitive restructuring	C-1	
C-2	Behavior modification	C-2	
C-3	Sand Tray	C-3	
C-4	Parenting skills training	C-4	
C-5	Family sculpting	C-5	

Section D Michelle

What assessment instruments would provide additional information for diagnosis and treatment planning?

Select as many as you consider indicated in this Section.

D-1.	Child Thematic Apperception Test (CAT)	D-1	
D-2.	Gessel	D-2	
D-3.	WISC R	D-3	
D-4.	WPPSI	D-4	
D-5.	Vineland Social Maturity Scale	D-5	
D-6.	MMPI	D-6	
D-7.	House Tree Person (HTP)	D-7	
	When you have completed your selections in this section, uncover response D-8	D-8	

Section E Michelle

To help Michelle and her parents integrate her treatment progress into other arenas, what information would you need? *Select as many as you consider indicated in this Section.*

E-1	Reports from her peer group	E-1	
E-2	Reports from physician	E-2	
E-3	School records	E-3	
E-4	Interview with minister	E-4	
E-5	Observation of brother	E-5	
E-6	Interview with teacher	E-6	
E-7	Guidance counselor records	E-7	
	When you have completed your selections in this section, uncover response E-8	E-8	

Section F Michelle

In development of a treatment plan what professional steps need to be taken?

Select as many as you consider indicated in this Section.

F-1	Obtain a school release	F-1	
F-2	Obtain a physician release	F-2	
F-3	Describe your successful parenting style to the parents	F-3	
F-4	Discuss limited confidentiality with Michelle	F-4	
F-5	Tape sessions for later use	F-5	
F-6	Discuss limited confidentiality with Michelle's parents	F-6	
F-7	Modify Michelle's diagnosis at the parent's request	F-7	
F-8	Obtain a consent for treatment	F-8	
	When you have completed your selections in this section, uncover response F-9	F-9	

Section G Michelle

In order to develop a treatment plan for the client, you will need to:

Select as many as you consider indicated in this Section.

G-1	Identify parenting goals	G-1	
G-2	Identify goals that the therapist has determined underlie the presenting problem	G-2	
G-3	Select interventions that target symptom relief	G-3	
G-4	Plan post treatment activities	G-4	
G-5	Develop goals that address identified issues	G-5	
	When you have completed your selections in this section, uncover response G-6	G-6	

Simulation 2 Ruth

Ruth, a 32 year old female, senior executive secretary, was referred for treatment by a friend following several seemingly unexplainable episodes of uncontrollable crying and trembling, causing her to leave work abruptly. You are a mental health counselor in private practice.

Section A Ruth

During your first session with Ruth, what information would you need to obtain to establish a provisional DSM-IV diagnosis? *Select as many as you consider indicated in this Section.*

A-1	Substance abuse	A-1	
A-2	Medical history	A-2	
A-3	Career history	A-3	
A-4	Psychosocial history	A-4	
A-5	Ethnic and religious affiliations	A-5	
A-6	Explore precipitating events	A-6	
A-7	Frequency of symptoms	A-7	
A-8	History of symptoms	A-8	
A-9	Relationship with friend	A-9	
A-10	5 year career plan	A-10	
When you have completed your selections in this section, uncover response A-11		A-11	

Section B Ruth

At the termination of this case, what recommendations would be made?

Choose only one unless you are directed to "Make another selection in this Section."

B-1	Referral to support group	B-1	
B-2	Couples therapy	B-2	
B-3	Singles group	B-3	
B-4	Family therapy	B-4	
	When you have completed your selections in this section, uncover response B-5	B-5	

Section C Ruth

What referral would be most important at this time?

Choose only one unless you are directed to "Make another selection in this Section."

C-1	Substance use evaluation	C-1	
C-2	Medical evaluation	C-2	
C-3	Career consultation	C-3	
C-4	Group therapy	C-4	
C-5	Sleep study	C-5	

Section D Ruth

Based on the data you have obtained, and information gathered, what provisional diagnosis DSM-IV can be made? *Choose only one unless you are directed to "Make another selection in this Section."*

D-1	Post Traumatic Stress Disorder	D-1	
D-2	Generalized Anxiety Disorder with Depressed Mood	D-2	
D-3	Acute Stress Disorder	D-3	
D-4	Anxiety Disorder with mixed Anxiety and Depressed Mood	D-4	

Section E Ruth

To assess the client's progress, what information would you gather?

Select as many as you consider indicated in this Section.

E-1	Sleep patterns	E-1	
E-2	Career interests	E-2	
E-3	Social contacts	E-3	
E-4	Cognitive functioning	E-4	
E-5	Financial management	E-5	
E-6	Follow-up on referrals	E-6	
E-7	Substance use	E-7	
E-8	Family contacts	E-8	
E-9	Volunteering as a rape crisis volunteer	E-9	
E-10	Results of Strong Campbell	E-10	
E-11	Results of Anxiety Disorder Interview Schedule	E-11	
E-12	Results of Beck Depression Inventory	E-12	
	When you have completed your selections in this section, uncover response E-13	E-13	

Section F Ruth

What techniques would you use in the next 10 sessions?

Select as many as you consider indicated in this Section.

F-1	Script analysis	F-1	
F-2	Geneogram	F-2	
F-3	Cognitive restructuring	F-3	
F-4	Psychodrama	F-4	
F-5	Relaxation techniques	F-5	
F-6	Clarification	F-6	
F-7	Working through	F-7	
F-8	Negative reinforcement	F-8	
When you have completed your selections in this section, uncover response F-9		F-9	

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Scoring for Problem 1

SIMULATION 1 MICHELLE

The path through the problem was: A - D - F - B - E - G - C - END

SECTION A
(Information Gathering)

Option	Score
A-1	−1
A-2	2
A-3	−1
A-4	1
A-5	−2
A-6	1
A-7	−1
A-8	−2
A-9	2
A-10	1
A-11	2

IG MPL/MAX for Section A
MPL: 6 MAX: 9

Your section A score:

SECTION B
(Decision Making)

Option	Score
B-1	1
B-2	−1
B-3	1
B-4	−1
B-5	−1
B-6	1
B-7	1

DM MPL/MAX for Section B
MPL: 2 MAX: 4

Your section B score:

SECTION C
(Decision Making)

Option	Score
C-1	−1
C-2	2
C-3	−1
C-4	−2
C-5	−1

DM MPL/MAX for Section C
MPL: 2 MAX: 2

Your section C score:

SECTION D
(Decision Making)

Option	Score
D-1	2
D-2	−1
D-3	1
D-4	−1
D-5	−2
D-6	−2
D-7	2

DM MPL/MAX for Section D
MPL: 3 MAX: 5

Your section D score:

SECTION E
(Information Gathering)

Option	Score
E-1	−2
E-2	2
E-3	1
E-4	−2
E-5	−1
E-6	2
E-7	1

IG MPL/MAX for Section E
MPL: 4 MAX: 6

Your section E score:

SECTION F
(Decision Making)

Option	Score
F-1	1
F-2	1
F-3	−1
F-4	1
F-5	−2
F-6	1
F-7	−2
F-8	1

DM MPL/MAX for Section F
MPL: 4 MAX: 5

Your section F score:

SECTION G
(Decision Making)

Option	Score
G-1	−1
G-2	−2
G-3	2
G-4	−1
G-5	1

DM MPL/MAX for Section G
MPL: 2 MAX: 3

Your section G score:

IG and DM Scores
(NOTE: These are in the order you completed the problem).

	IG		DM
A		B	
E		C	
		D	
		F	
		G	
Your Total			

IG DM
MPL: 10 MAX: 15 MPL: 13 MAX: 19

Scoring for Problem 2

SIMULATION 2 RUTH

The path through the problem was: A - D - F - C - E - B - END

SECTION A
(Information Gathering)

Option	Score
A-1	2
A-2	1
A-3	−2
A-4	2
A-5	−1
A-6	2
A-7	1
A-8	2
A-9	−2
A-10	−2

IG MPL/MAX for Section A
MPL:8 MAX:10

Your section A score: ☐

SECTION B
(Decision Making)

Option	Score
B-1	2
B-2	−2
B-3	−1
B-4	−1

DM MPL/MAX for Section B
MPL:2 MAX:2

Your section B score: ☐

SECTION C
(Decision Making)

Option	Score
C-1	−1
C-2	2
C-3	−2
C-4	−1
C-5	−1

DM MPL/MAX for Section C
MPL:2 MAX:2

Your section C score: ☐

SECTION D
(Decision Making)

Option	Score
D-1	2
D-2	−2
D-3	−1
D-4	−2

DM MPL/MAX for Section D
MPL:1 MAX:2

Your section D score: ☐

SECTION E
(Information Gathering)

Option	Score
E-1	1
E-2	−2
E-3	2
E-4	1
E-5	−2
E-6	2
E-7	−1
E-8	−1
E-9	1
E-10	−2
E-11	2
E-12	−1

IG MPL/MAX for Section E
MPL:6 MAX:9

Your section E score: ☐

SECTION F
(Decision Making)

Option	Score
F-1	−2
F-2	−1
F-3	1
F-4	−2
F-5	1
F-6	1
F-7	1
F-8	−1

DM MPL/MAX for Section F
MPL:3 MAX:4

Your section F score: ☐

IG and DM Scores
(NOTE: These are in the order you completed the problem).

	IG		DM
A	☐	B	☐
E	☐	C	☐
		D	☐
		F	☐
Your Total	☐		☐
	IG MPL: 14 MAX: 19		DM MPL: 8 MAX: 10

PART III

Tools

◆ ◆ ◆

Time Management Forms
Crossword Puzzles (Back pocket of binder).
Flashcards (Back pocket of binder).

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SELF MANAGEMENT AND PERSONAL LEADERSHIP

The following time management forms are provided to help you manage your study program. The *Plan/Milestone* form helps you create an overview of your journey to licensure. The codes at the bottom can be customized for activities. The circle can be study groups, the triangle personal study time etc. Create a schedule of events by beginning with the *Monthly* schedule. If this fills up go to a *Weekly* schedule. If you find this does not allow for enough detail use the *Daily* schedule. If you find you are not following your study schedule, track your activities for a week on the *Time Log* form. This will provide you with a sense of how you are using your time to NOT study. As you work your plan, and think of books, course notes, or any other activity you believe would help you pass the exam, make a note of the activity on the *Action* worksheet and review it at the end of each day. Schedule the activity on your study plan to make it happen. Review the *Study Schedule* in the Test Taking chapter for the optimal study plan. The *Journal* form provides a place to write your thoughts and feelings about preparing for the examination. As you write you may think of new action items. Transfer these activities to your *Action* worksheet and be sure to schedule it to make certain it actually happens. If you find this kind of self-management system works for you and want to know more about this process, we recommend the Franklin Day Planner and the Franklin Quest training programs. They can be contacted at (800) 963-1776. The self-management forms included in this workbook include:

- Plan/Milestone
- Action
- Journal
- Time Log
- Schedule Daily
- Schedule Weekly
- Schedule Monthly

Time Log

Time	Activity						Feelings/Thoughts
7:00							
7:45							
8:10							
8:45							
9:15							
9:50							
10:20							
11:30							
12:10							
13:05							
13:40							
14:25							
15:05							
16:15							
16:30							
17:00							
17:45							
18:45							
19:30							

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SCHEDULE WEEKLY

MONDAY	TUESDAY	WEDNESDAY
7:00		
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SCHEDULE WEEKLY

THURSDAY	FRIDAY	SATURDAY
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SCHEDULE - Monthly

MONTH ____________________ **YEAR** ____________

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
#1							
#2							
#3							
#4							

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Schedule - Daily

Date	Day

Priority	Item	Time Needed	Done
			☐
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Notes	Obtain

Scheduled Events	
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7:00	

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Plan / Milestone

Event																						

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JOURNAL

Subject: ______________________

Date	Notes	Action

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Action

Date/Project	Priority	Est. Time	To Do	Due	✔
1					
2					
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27					

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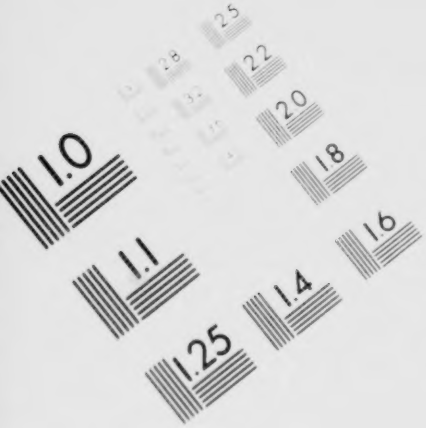
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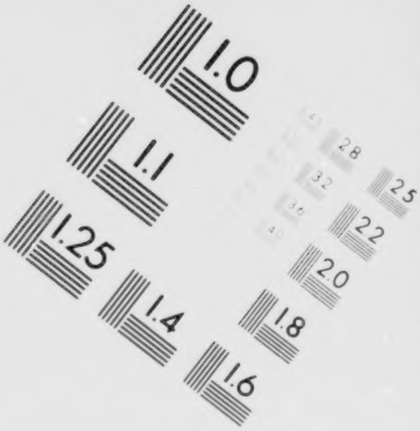
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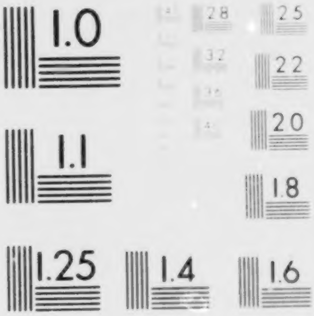
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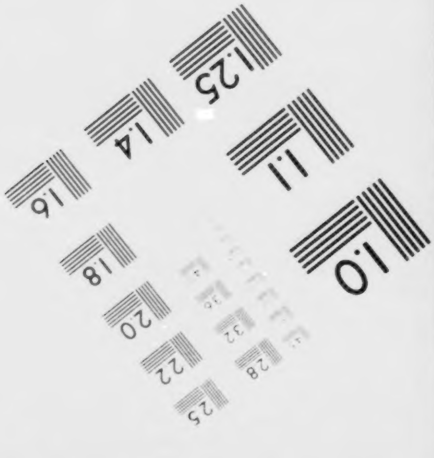
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1.1
1.6
1.0
1.8
2.0
2.2
2.8
2.5

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INDEX

A
Abandonment 248
Abuse 289
Abused children 153
Abusive Parents 151
Achievement tests 38
Adjustment Disorders 55, 73, 106, 290
Adler 12
Adlerian Psychology 12
Adolescents 290
Age Factors 19
AIDS 256
Alcohol 62, 84, 169, 170, 198
Alcohol Screening Tools 170
Alcoholism 290
Amphetamine Use Disorder 62, 171
Amphetamines 200
Analytical Psychology 13, 116
Anastasi 21, 27, 29
Anna Freud 117
Anorexia 290
Anticholinergic 189
Antidepressants 193
Antipsychotics 188
Anxiety Disorders 25, 54, 69
Anxiety Scale 273
Anxiolytic Use Disorders 65, 181
Anxiolytics 191
Appraisal 21
Assessment 21, 22, 23, 24, 37, 38, 49, 52, 129, 163, 204
Assessment Interview 24
Attitudes 268

B
Bandura 6, 119, 148
Barbiturates 197
Battered women 154
Beck 21, 40, 118, 148, 156
Behavior Therapy 118
Behavioral Assessments 34
Bender Gestalt Test 31
Berne 120, 137
Blanck and Blanck 14
Bowlby 16
Brief treatment 147

C
Caffeine Related Disorders 84, 172
California Psychological Inventory (CPI) 30
Cannabis 63, 84, 173, 202, 203
Career Assessment Instrument 38
Career Planning 229
Child Abuse and Neglect 151
Children 291
Classical Conditioning 5, 118
Client variables 221
Clinical Notes 256
Clinical Report 48
Co-alcoholic 291
Cocaine Abuse 63, 175
Cognitive Development Theories 5
Cognitive Therapy 118
Cognitive-Behavioral Therapy 118
Cognitive-Structural 5, 6
Concrete Operational Thought 7
Confidentiality 139, 240, 251
Conflict Resolution/Mediation 149
Consultive Models 241
Counseling Theories 115
Couples 291
Court Appearances 253
Crisis Intervention 148, 291
Crites 236, 237
Crossword Puzzles 268

D
Danger to Others 251
Decision Making Models 232
Defense Mechanisms 10, 77
Delirium 54, 60, 78, 83
Delirium, Dementia, & Amnestic & Other Cognitive Disorders 54, 83
Denial 269
Dependence Syndrome 163
Depression 292
Desensitization 273
Developmental issues 292
Diagnosis 25, 43, 52, 53, 56, 57, 76, 79, 80, 163, 164, 221
Disorders Usually First Diagnosed in Infancy, Childhood, or
  Adolescence 54, 58, 81
Dissociative Disorders 55, 70
Divorce 292
Domestic Violence 154, 293
Drug Tolerance 187
DSM-IV 52, 53, 55, 58, 77, 78
Dual Diagnosis 87, 164
Dual Relationship 249
Durkheim 155
Duty to Warn 251, 293

E
Eating Disorders 55, 59, 71, 82, 101, 102, 135, 293
Ego Psychology 117
Elder Abuse 255
Elderly 19
Elderly Populations 157
Ellis 118
Emancipation 293
Environment 3, 4, 5, 55, 149
Environmental Learning 4, 5
Erikson 117

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Ethnic 293
Eustress 272
Existential Psychotherapy 120
Extrapyramidal Effects 190

F

Factitious Disorders 54, 69, 93, 94
Fairbairn 14
Families 294
Family Assessments 35
Formal Operations 7
Freud 9, 18, 115

G

Gay/Lesbian issues 294
Gendlin 120
Geneograms 37, 130
Gestalt Therapy 119
Glasser 120
Goal Setting 267
Gottfredson 233
Gravely disabled 294
Grief 295
Growth And Development 3, 7

H

Hallucinogen Related Disorders 63, 84, 176
Hallucinogens 202
Hartman 117
Heredity 3
Holland 39, 234
Hoppock 235
Horner 14
Horney 12, 148
House Tree Person 34
Humanistic Therapies 119

I

Impulse-Control Disorders Not Elsewhere Classified 55
Incomplete Sentences Blank 34
Informed Consent 240, 250, 295
Inhalant Related Disorders 64, 84, 177
Instinctual drives 10
Intelligence 27, 48, 51
Interpersonal Psychotherapy 14
Involuntary confinement 295

J

Jung 13, 116

K

Kernberg 14, 117
Kohlberg 15
Kohut 117

L

Language Development 7
Lazarus 118
Legal issues 295
Lesbian and Gay Clients 159
Levinson 19
Lichtenstein 117
Life-career rainbow 234
Lorenz 16
Luria Nebraska 31

M

Malpractice 248
Managed Care 148
MAO Inhibitors 195
Maslow 14, 15
MBTI 285
Memory Chains 271
Mental Disorder 54, 75, 84
Mental Disorders Due to a General Medical Condition 54, 61, 84
Mental Retardation 54, 55, 58, 77, 81
Mental Status 23, 25, 43, 45, 49, 163
Minnesota Multiphasic Personality Inventory (MMPI) 30
Minority Clients 158
Minors 253
Moderate and Long Term Therapy 148
Mood Disorders 54, 67, 68, 87
Mood Stabilizers 195
Moral Development 15
Multiaptitude Test 37
Multiaxial System 77
Myers-Briggs Type Indicator (MBTI) 31

N

Negligent Evaluation 248
Neo-Freudians 11, 116
Nicotine Dependence 64, 178

O

Object Relations Theory 14
Obsessive 295
Operant Conditioning 5, 118
Opioid Use Disorder 179
Opioid-Analgesics 198
Organizational Consultation 239, 240
Orthostatic Hypotension 190

P

Parenting Styles 18
PCP 65, 84, 180, 202
Perls 119, 136
Perpetrators 154
Person-Centered Therapy 119
Personality and Social Development 9
Personality Disorders 54, 55, 74, 77, 107
Personality Style 268
Personality tests 29
Pharmacokinetics 186
Phencyclidine Use Disorders 65, 180
Physical Disabilities 158
PHYSICAL Exercises 274
Piaget 6
Polysubstance Abuse 182
Pre-marital 296
Preoperational/Symbolic Thought 6
Prescription Drug Abuse 184
Prevention 225, 228
Privilege 296
Privileged Communications 252
Procrastination 269
Professional Practice 245
Projective Tests 32
Psychoanalysis 115
Psychodynamic Psychotherapies 115
Psychopharmacology 185
Psychosocial Development 11

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R
Rapaport 117
Rational Emotive Therapy 118
Reality Therapy 120
Reality therapy 106, 120
REBT 118
Record Keeping 256
Record Storage 257
Recrudescence 184
Referral 256, 296
Reframing 269
Religion 297
Research and Evaluation 205
Retention 271
Reverse Tolerance 162
Ritalin 201
Roe 235
Rogers 119
Rorschach 32
Runaway 297

S
Saturation 264
Schizophrenia and Other Psychotic Disorders 54, 66, 85
Scholastic Tests 38
Scope Of Practice 248
Sedatives Hypnotics 196
Self Psychology 117
Self-Actualization theory 14
Self-Reports 40
Seniors 297
Sensorimotor 6
Sex Role Development 17
Sexual and Gender Identity Disorders 55, 70, 78
Sexuality 297
Single parents 297
Sixteen Personality Factor Questionnaire (16 PF) 31
Skinner 5, 118
Sleep Disorders 26, 55, 72, 102
Social Learning Theory 6
Somatoform Disorders 54, 69
Special Treatment Issues 151
Stages of Adulthood 19
Stages of Consultation 241
Stanford Binet 27, 28
Statistics 211
Steps to Diagnosis 79
Strong-Campbell 39
Structured Family Interview 35, 36
Study Groups 267
Study Plan 264
Study Plan Guide 277
Study Schedule 266
Substance abuse 298
Substance Abuse Disorders 161
Substance Related Disorders 54, 61, 66, 84, 184
Suicide 155, 251, 298
Sullivan 116
Super 233
Symptom rebound 183
Synergism 187

T
Test resources 23
Testing 27, 298
Thematic Apperception Test (TAT) 33
Therapeutic Alliance 220
Therapist Variables 221
Transactional Analysis (TA) 120
Treatment Factors 222
Treatment Modalities 147, 166
Treatment Planning 23, 81, 204
Triggers 273
Types of Statistics 211

U
Unprofessional Conduct 246
Useless treatment 249

V
Values Assessment 37
Vicarious Liability 250
Violence 299

W
Wechsler Tests 27
Wiltwyck Family Task 35
Wolpe 118

STUDY MATERIAL RECOMMENDATIONS

If you are sitting for the NBCC NCMHCE exam we recommend you obtain the following materials as an adjunct to this workbook:

- Preparation Guide for the National Clinical Mental Health Counseling Examination (NCMHCE)
- NBCC Code of Ethics

Contact NBCC @ PO Box 651051, Charlotte, NC 28265-1051, Telephone 910.547.0607

- AMHCA National Standards for Clinical Practice and Training, including AMHCS's Code of Ethics

Contact AMHCA @ 801 North Fairfax St., Suite 304, Alexandria, VA 22314, Telephone (703) 548-6002

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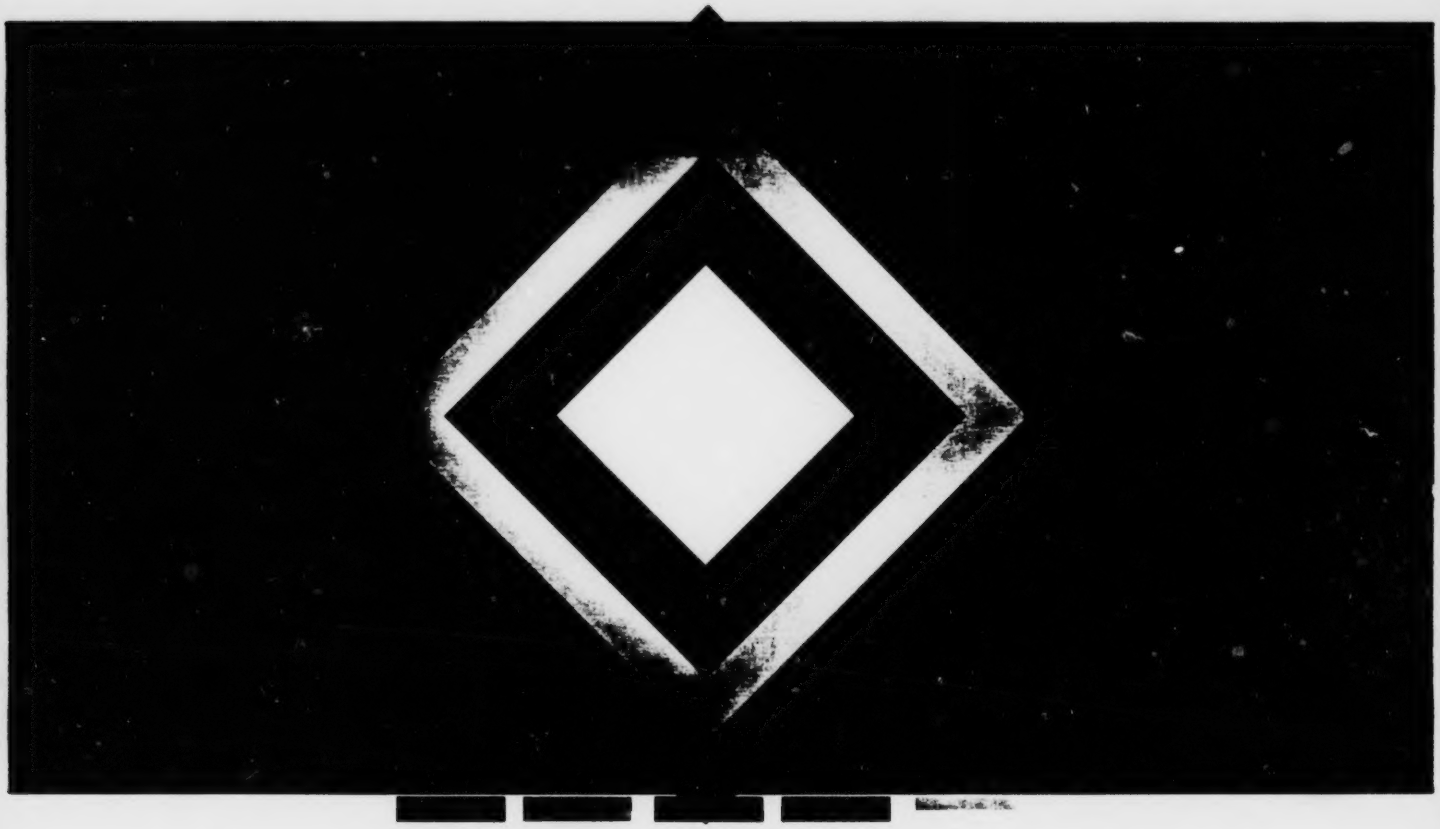
CLINICAL MENTAL HEALTH COUNSELOR

Flashcards



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Professional Training Institute
P.O. Box 393
Sudbury, MA 01776

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AMHCA
**American
Mental
Health
Counselors
Association**

- **Category**
  Tricyclic
- **Type**
  Antidepressant
- **Indications**
  endogenous depression and other depressions involving decreased appetite and weight loss, sleep disturbances, psychomotor retardation, anhedonia, and diurnal mood variations; severe phobia, hypochondriacal, and obsessive states; chronic pain

---

- **Category**
  Tricyclic
- **Type**
  Antidepressant
- **Indications**
  endogenous depression and other depressions involving decreased appetite and weight loss, sleep disturbances, psychomotor retardation, anhedonia, and diurnal mood variations; severe phobia, hypochondriacal, and obsessive states; chronic pain

---

- **Category**
  Phenothiazine
- **Type**
  Antipsychotic
- **Indications**
  disordered thought; psychomotor agitation in psychosis; mania

---

- **Category**
  Phenothiazine
- **Type**
  Antipsychotic
- **Indications**
  withdrawal, apathy and psychomotor retardation in schizophrenic hallucinations and delusions
  Antipsychotic

- **Category**
  Phenothiazine
- **Type**
  Antipsychotic
- **Indications**
  disordered thought; psychomotor agitation in psychosis; mania

---

- **Category**
  MAO Inhibitor
- **Type**
  Antidepressant
- **Indications**
  atypical depressions (involving anxiety, increased appetite, hypochondriasis or hostility); phobic disorders

---

- **Category**
  MAO Inhibitor
- **Type**
  Antidepressant
- **Indications**
  atypical depressions (involving anxiety, increased appetite, hypochondriasis or hostility); phobic disorders

---

- **Category**
  Tetracyclic
- **Type**
  Antidepressant
- **Indications**
  endogenous depression and other depressions involving decreased appetite and weight loss, sleep disturbances, psychomotor retardation, anhedonia, and diurnal mood variations; severe phobia, hypochondriacal, and obsessive states; chronic pain

---

- **Category**
  Tricyclic
- **Type**
  Antidepressant
- **Indications**
  endogenous depression and other depressions involving decreased appetite and weight loss, sleep disturbances, psychomotor retardation, anhedonia, and diurnal mood variations; severe phobia, hypochondriacal, and obsessive states; chronic pain

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PS

Trade name
NARDIL
Generic name
PHENELZINE

PS

Trade name
PARNATE
Generic name
TRANYLCYPROMINE

PS

Trade name
LUDIOMIL
Generic name
MAPROTILINE

PS

Trade name
ELAVIL
Generic name
AMITRPTYLINE

PS

Trade name
SINEQUAN
Generic name
DOXEPIN

PS

Trade name
TOFRANIL
Generic name
IMIPRAMINE

PS

Trade name
MELLARIL
Generic name
THIORIDAZINE

PS

Trade name
STELAZINE
Generic name
TRIFLUOPERAZONE

PS

Trade name
THORAZINE
Generic name
CHLORPROMAZINE

- **Category**
- **Type**
  Opioids
- **Indications**
  none found

- **Category**
- **Type**
  Hallucinogen
- **Indications**
  Similar to LSD but more intense

- **Category**
- **Type**
  Opioids
- **Indications**
  analgesic

- **Category**
- **Type**
  Opioids
- **Indications**
  analgesic, cough suppressant

- **Category**
- **Type**
  Opioids
- **Indications**
  analgesic, antidiarrheal

- **Category**
- **Type**
  Opioids
- **Indications**
  analgesic

- **Category**
- **Type**
  Opioids
- **Indications**
  analgesic, antidiarrheal, cough suppressant

- **Category**
- **Type**
  Opioids
- **Indications**
  analgesic

- **Category**
- **Type**
  Opioids
- **Indications**
  analgesic, antidiarrheal, cough suppressant

PS

Trade name
STP
Generic name
DIMETHAXYMETHYL-
AMPHETAMINE

PS

Trade name
HEROIN
Generic name

PS

Trade name
CODEINE
Generic name

PS

Trade name
MORPHINE
Generic name

PS

Trade name
DARVON
Generic name
PROPOXPHENE

PS

Trade name
OPIUM
Generic name

PS

Trade name
DEMEROL
Generic name
MEPERIDINE

PS

Trade name
PERCODAN
Generic name
OXYCODONE

PS

Trade name
DILAUDAD
Generic name
HYDROMORPHONE

- **Category**
  Benzodiazepine
- **Type**
  Antianxiety
- **Indications**
  Antianxiety, alcohol withdrawal

- **Category**
  Benzodiazepine
- **Type**
  Antianxiety
- **Indications**
  Antianxiety

- **Category**
  Benzodiazepine
- **Type**
  Antianxiety
- **Indications**
  Antianxiety, muscle relaxant, anti convulsant

- **Category**
  Benzodiazepine
- **Type**
  Antianxiety
- **Indications**
  Antianxiety

- **Category**
  Propanediols
- **Type**
  Antianxiety
- **Indications**
  Antianxiety, anti convulsant, muscle relaxant

- **Category**
- **Type**
  Amphetamine
- **Indications**
  narcolepsy, hyperkinesis

- **Category**
- **Type**
  Amphetamine
- **Indications**
  narcolepsy, hyperkinesis

- **Category**
- **Type**
  Amphetamine
- **Indications**
  narcolepsy, hyperkinesis, acute hypotension

- **Category**
- **Type**
  Anti-manic
- **Indications**
  Manic episodes, bipolar affective disorder

- **Category**
  Benzodiazepine
- **Type**
  Antianxiety
- **Indications**
  Hypnotic

PS

Trade name
BENZEDRINE
Generic name
AMPHETAMINE

PS

Trade name
DEXEDRINE
Generic name
DEXTROAMPHETAMINE

PS

Trade name
METHEDRINE/DESOXYN
Generic name
METHAMPHETAMINE

PS

Trade name
LITHIUM CARBONATE
Generic name

PS

Trade name
DALMANE
Generic name
FLURAZEPAM

PS

Trade name
LIBRIUM
Generic name
CHLORDIAZEPOXIDE

PS

Trade name
SERAX
Generic name
OXAZEPAM

PS

Trade name
VALIUM
Generic name
DIAZEPAM

PS

Trade name
XANAX
Generic name
ALPRAZOLAM

PS

Trade name
MILTOWN/EQUANIL
Generic name
MEPROBAMATE

- **Category**
- **Type**
  Hallucinogen
- **Indications**
  Similar to LSD but more intense

- **Category**
- **Type**
  Hallucinogen
- **Indications**
  Altered states of consciousness

- **Category**
- **Type**
  Hallucinogen
- **Indications**
  Similar to LSD but more intense and with greater euphoria

- **Category**
- **Type**
  Hallucinogen
- **Indications**
  disorientation; dissociation; hallucinations, perceptual distortion anxiety and restlessness

- **Category**
- **Type**
  Hallucinogen
- **Indications**
  Similar to LSD but more intense and with greater euphoria and paranoia

- **Category**
  Phenothiazine Navane Haloperidol
- **Type**
  Antipsychotic
- **Indications**
  Withdrawal, apathy and psychomotor retardation in schizophrenia, hallucinations and delusions
  Anti psychotics Butyrophenones

- **Category**
- **Type**
  Barbituate
- **Indications**
  sleep disorders

- **Category**
- **Type**
  Barbituate
- **Indications**
  convulsions - side effects to other drugs

- **Category**
- **Type**
  Barbituate
- **Indications**
  hypnosis

- **Category**
- **Type**
  Barbituate
- **Indications**
  sleep disorders

PS

Trade name
PROLIXIN
Generic name
FLUPHENAZINE

PS

Trade name
AMYTAL
Generic name
AMOBARBITAL

PS

Trade name
LUMINAL
Generic name
PHENOBARBITAL

PS

Trade name
NEMBUTAL
Generic name
PENTOBARBITAL

PS

Trade name
SECONAL
Generic name
SECOBARBITAL

PS

Trade name
DMT
Generic name
DIMETHYLTRYPTAMINE

PS

Trade name
LSD
Generic name
LYSERGIC ACID DIETHYLAMIDE

PS

Trade name
MESCALINE
Generic name
PEYOTE

PS

Trade name
PCP
Generic name
PHENCYCLIDINE

PS

Trade name
PSILOCYBIN
Generic name
DIMETHAXYMETHYLAMPHETAMINE

- Individual and environmental
- The greater the number the higher the degree of risk mental illness
- Institutional factor
- A focus of interventions
- Occupational Setting
- Gene risk
- How one grows across the life span
- Window of opportunity sequentially ordered
- Sequences in family development and the relationships between parents
- Identification with delinquent youth group

PR

Biological Influence

PR

Developmental Factors

PR

Developmental Timing

PR

Family Factor

PR

Peer Factor

PR

Protective Factor

PR

Risk

PR

School

PR

Universal

PR

Workplace

- The number of locks your records need to be kept behind

- Utilization review

- If your client is not making progress you could be guilty of _____ treatment

- Four times a day

- You are legally bound to work within the _____ of your practice

- A type of clinical note that is recommended for clinicians

- After how many visits do you need to make a clinical evaluation and treatment plan?

- Three times a day

PP

QID

PP

Scope

PP

SOAP

PP

Three

PP

TID

PP

Two

PP

UR

PP

Useless

- Diagnosis
- Before you engage in treatment you must disclose this to your new client
- One of your client's rights
- A person who has not been emancipated
- An exchange of information between two people that is confidential is a _____ communication
- Neglect and abandonment of a minor
- Keeping all communications private
- When you have another role other than counseling in your client's life
- One of the only times you break confidentiality is when there is a _____

PP

Child Abuse

PP

Confidentiality

PP

Dual Relationship

PP

Duty to Warn

PP

DX

PP

FEE

PP

Informed Consent

PP

Minor

PP

Privileged

- Benzodiazepine

- A therapeutic intervention used with hallucinogen users

- A vitamin used in treatment of alcoholics

- Need for more to achieve similar results

- The use of a substance to relieve or avoid withdrawal symptoms

SA

Talkdown

SA

Xanax

SA

Thiamine

SA

Tolerance

SA

Withdrawal

- A maladaptive pattern leading to clinically significant impairment or distress
- Individual symptoms for each substance
- Presumes no prior diagnosis of dependency and does not require impairment or distress from a maladaptive pattern within a 12-month period
- Drug is withdrawn and symptoms reappear
- A blending of senses
- First stage of substance abuse
- First stage of treatment with substance abuse
- The decision point
- Symptom reemerges
- The arena that supports early substance use

SA

Preabuse

SA

Precontemplation

SA

Preparation

SA

Recrudescence

SA

Social

SA

Substance Dependence

SA

Substance Withdrawal

SA

Substance Abuse

SA

Symptom Rebound

SA

Synthesis

- Hallucinogen

- Methadone used as an intervention

- Phencyclidine

- Unintended use of larger amounts or for longer than intended

- Patients are often severely and chronically ill

- Coexistence of a major psychiatric illness and substance dependence or abuse

- Often happens after chronic use of hallucinogens

- Can be life threatening

- Reversible syndrome

SA

Dual Diagnosis

SA

Dual Diagnosis

SA

Flashback

SA

Inhalant

SA

Intoxication

SA

MDMA

SA

Opioid

SA

PCP

SA

Persistence

- Self report questionnaire
- C - Cutback

A - Annoying
G - Guilty
E - Eye Opener

- Presumes no prior diagnosis of dependence

- Is often difficult to develop therapeutic relationship with this abuser

- The use of a substance to relieve or avoid withdrawal symptom

- Acknowledgement of personal responsibility with minimal willingness to change

- Depressant

- The first most difficult issue to address in treatment

- Antabuse

- Scale and Symptom development

- A substance almost everyone consumes daily

SA

Abuse

SA

Addiction

SA

Alcohol

SA

Aversive

SA

Caffeine

SA

Cage

SA

Cannabis

SA

Contemplation

SA

Denial

SA

Dependence Syndrome

- A person's orientation and preference regard to career

- Trait factoring

- System of interactive guidance and information files

- Developmental stages & vocational developmental tasks

CP

Lifestyle

CP

Parsons

CP

SIGI

CP

Super

- Helping people understand and act on their knowledge of work
- Personality based
- Needs approach
- Potential for self improvement
- A person in a position doing a set of tasks
- Computer linked exploration of careers and training
- Consultation
- Comprehensive model
- H.B. Gelatt

CP

CLECT

CP

Competencies

CP

Crites

CP

Decision

CP

Guidance

CP

Holland

CP

Hoppock

CP

I Power

CP

Job

- AA
- Drugs - therapeutic communities, support groups
- Length of use?
- Is there a loss of control over use?
- Assess physiological addiction
- Refer to educational, school or clinical psychologist
- Assess signs of addiction
- Social/occupational complications?

- Dependent on parent/child relationship
- Foster placement?
- Protective agency?
- See child alone & assess individual and relationship with parents

- Assess Lethality, Plan, Means, Isolation
- Privilege waived
- Remove means
- Plan for interventions by self and friends/family
- Counseling
- Future Management

- Physical abuse
- Fiscal abuse
- Health issues
- Support networks

- Types of tests
- When to refer

- Grief work
- Financial problems
- Isolation
- Job/status
- Medical problems
- Positive use of life
- Validate feelings

- Assess immediate potential
- If a danger call police

- Master & Johnson's sensate focus techniques

- Coping skills
- Support groups

KA

Runaway

KA

Seniors

KA

Seniors

KA

Sexuality

KA

Single Parents

KA

Substance Abuse

KA

Suicide

KA

Testing

KA

Violence

- Communication skills
- Expectations
- Families of origin?
- Marriage myths
- Secondary deals
- Why getting married

- Grief process - DABDA
- Suicide potential?
- For any major loss

- Held by people over 18
- Privilege disappears when?
- With minor, negotiate what family will be told about

- Identify stages
  - Pre-Contemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance

- 1st gain trust
- Obtain written release

- Confidentiality issues
- Discomforts & risks
- Explain counseling procedures, objectives, seen how often
- Right to leave treatment
- Therapists role and qualifications
- Legal determinants

- Explore belief system

- Amnesia
- Delirium
- Delusions
- Dementia
- Drug/alcohol withdrawal
- Hallucinations
- Odd affect
- Organic Brain Syndrome
- Personality disorder

- Check abuse, incest

- Communication skills with children/spouse
- Discipline techniques

KA

Grief

KA

How Does Change Take Place in Therapy

KA

Informed Consent

KA

OBS

KA

Parenting

KA

Pre-Marital

Privilege

KA

Referrals

KA

Religion

KA

Runaway

- Enters military
- ID card/marriage license
- Lives separately willingly
- Manages own money
- Through legal process without consent of parents
- Through marriage with consent of parents

- Catharsis assessment
- Focusing/contracting
- Intervention/resolution
- Termination/integration

- Ask them for help with differences
- Communication issues
- Cultural values
- Referral
- Stereotyping

- Acknowledge & allow it
- Ask - What would happen if you were not depressed?
- Check for substance abuse
- Grief work
- Pattern recognition (journal work, creative arts, previous depressions)
- Structure time use

- Communications system open/closed
- Family history 2 generations
- Family structure
- Interventions
- Roles/rules/myths

- Kids needs
- Parents needs

- Age related issues
- Family related issues

- Call police
- Warn intended victim or someone who can tell them

- Mental & physical status
- Physical exam
- 72 hour evaluation mental
- Hospitalization

- Medical exam
- Nutritionist

KA

Crisis Interventions

KA

Depression

KA

Divorce

KA

Duty to Warn

KA

Eating Disorders

KA

Emancipation

KA

Ethnic

KA

Families

KA

Gay Issues

KA

Gravely Disabled

- Age appropriate behavior
- Piaget

- Protect person from further abuse
- Inform of options and sources of support
- Report within 24 hours, written 36 hours
- Separate parents from child while informing them of legal rights
- Know the Signs

- Impaired social or occupational functioning
- Maladaptive reaction to stressor

- Family sculpting
- Observations of children with family
- Play therapy/sand tray
- Role playing
- Same as adolescents

- Age appropriate behaviors
- Parenting classes
- Peer groups
- School records
- Who holds the privilege (parent/guardian)

- Angry about alcoholics behavior

- Change in drinking behavior patterns
- Interrupt coalitions
- Medical exam
- Multigenerational analysis of alcohol use
- Recovery similar to rebirth
- Take responsibility for self

- Communication patterns
- Define expectations clearly
- Explore degree of differentiation from families of origin
- If they're under 21 wonder about why they're marrying
- Myths of marriage and marriage contracts
- Over 21 history of previous relationships/marriages

- History
- Medical exam
- Work with expressing emotions
- Increase self esteem

KA

Abuse

KA

Adjustment Disorder

KA

Adolescents

KA

Alcoholism

KA

Anorexia

KA

Child Developmental Issues

KA

Children

KA

Co-Alcoholic

KA

Couples

- **Theoretical orientation**
  Strategic Family Therapy
- **Major concepts**
  Paradoxical Prescription

- **Theoretical orientation**
  Strategic Family Therapy
- **Major concepts**
  Neurolinguistic Programming

FM

P. Papp

FM

Grinder & Bandler

- **Theoretical orientation**
  Strategic Family Therapy
- **Major concepts**
  Therapeutic paradox

- **Theoretical orientation**
  Object Relations
- **Major concepts**
  Separation - Individuation

- **Theoretical orientation**
  Existential Family systems
- **Major concepts**
  Therapist as active family participant

- **Theoretical orientation**
  Strategic Family Therapy
- **Major concepts**
  first and second order change; problem formulation - resolution communication

- **Theoretical orientation**
  Family systems
- **Major concepts**
  Undifferentiated Family Ego-mass

- **Theoretical orientation**
  Structural Family Therapy
- **Major concepts**
  "Boundaries"

- **Theoretical orientation**
  Object Relations
- **Major concepts**
  Pseudomutuality - Pseudohostility

- **Theoretical orientation**
  Existential Family systems
- **Major concepts**
  Communication Skills

- **Theoretical orientation**
  Existential Family systems
- **Major concepts**
  Mystification

- **Theoretical orientation**
  Psychodynamic-Systems
- **Major concepts**
  Resolution of grief reaction

FM

J. Framo

FM

Jay Haley

FM

R. Watzlawick

FM

Carl Whitaker

FM

S. Minuchin

FM

Murray Bowen

FM

V. Satir

FM

Helen Singer

FM

B. Paul

FM

R.D. Laing

- Focusing on underlying issues and getting a clear picture
- Helping others clarify goals
- Capturing what another said and adding meaning or clarification
- Gestalt
- Moreno

- A major leader in the field of group therapy
- Created the theater of spontaneity
- A kind of listening that communicates to the other that they have been heard
- Being able to freely express feelings

GR

Clarifying

GR

Yalom

GR

Facilitating

GR

Moreno

GR

Restarting

GR

Active

GR

Perls

GR

Catharsis

GR

Psychodrama

◆ There is appropriate and premature _____

◆ An awareness of emotions previously blocked from consciousness

◆ A set of group rules

◆ When several members of a group align against an individual

◆ Sensing the subjective world of others

◆ Ellis

◆ 12-step support group

◆ Lewinof

◆ Berne

◆ Poor ego structure is a _____ for group therapy

BEST COPY AVAILABLE

GR

Rational Emotive

GR

AA

GR

T Group

GR

TA Group

GR

Contraindication

GR

Termination

GR

Abreaction

GR

Norms

GR

Scapegoating

GR

Empathy

◆ **Intelligence**
Intelligence
02-adult
Cross cultural
Scales that correlate to other measures of intelligence
Individual

◆ **Intelligence**
Infant & Preschool
Individual

◆ **Intelligence**
Intellectual & motor functioning
0 through 6.4 years
Personal social, fine motor, language, gross motor measured
Individual

◆ **Intelligence**
Intelligence
03-6
Hearing impaired
Scales that correlate to Stanford Binet & WISC
Individual

◆ **Intelligence**
Verbal, numerical & ability to follow directions
Adult/Industry
Individual

◆ **Projective**
Personality conflicts
04-Childhood
Patient makes up stories after viewing pictures
Individual

◆ **Projective Visual Motor Development**
Personality conflicts, ego function and structure, organic brain damage
05-adult
Patient's reproduction of geometric figures
Individual

◆ **Social Maturity**
Capacity for independent functioning
Performance on developmental tasks that assess social functioning
01-25 + years
Interview (parent, patient or legal guardian)
Individual

◆ **Values to needs**
Values
8-Adult
Values sorted by most important to least important
Individual

◆ **Intelligence**
Intellectual
02-30 months
Mental age
Individual

AS

Children's Apperception Test (CAT)

AS

Leiter International Performance

AS

Bender Visual Motor Gestalt

AS

McCarthy Scales of Children's Abilities

AS

Vineland Social Maturity Scale

AS

Orthopedic Handicaps
Individual Denver
Developmental Screening Test

AS

Values Assessment

AS

Hiskey-Nebrasks Test of Learning Ability

AS

Cattell Infant Intelligence Scale

AS

Personnel Test for Industry

◆ **Personality - projective**
Individual

◆ **Personality - projective**
Personality conflicts, ego function/structure, defensive structure, thought processes, affective integration
03-Adult
Patient's free associations to inkblots
Individual

◆ **Personality - projective**
Personality conflicts
Adult
Patient makes up stories about stimulus pictures
Individual

◆ **Personality - projective**
Personality conflicts, ego function, visual-motor coordination, intellectual functioning, self-image, family perception
02-Adult
Patient draws on a blank sheet of paper
Individual

◆ **Personality - objective**
Organic brain damage
Individual

◆ **Personality - objective**
Personality type based on C. Jung's personality model
10-Adult
Personality profile
Individual or group

◆ **Personality - objective**
Individual

◆ **Personality - objective**
Self-concept
Individual

◆ **Preschool**
Cognitive, language, motor, and social
01-60 mos.
Performance on developmental tasks.
Individual

AS

Luria Nebraska Neuropsychological Battery

AS

Myers-Briggs Type Indicator (MBTI)

AS

Millon Clinical Multiaxial Inventory (MCMI)

AS

Tennessee Self-Concept Scale

AS

Gessell Developmental Schedules

AS

Incomplete Sentences

AS

Rorschach

AS

Thematic Apperception Test (TAT)

AS

Draw a Person Draw a Family House-Tree

◆ **Paper & pencil personality inventory**
Personality structure, diagnostic classification
11-Adult
Personality profile reflecting 9 dimensions of personality; diagnosis based on actuarial prediction
Group

◆ **Personality - objective**
Problem solving, stress, relationships, work, career and growth
Individual

◆ **Personality - objective**
Personality
14-Adult
Personality profile
Individual

◆ **Personality - objective**
Personality
Individual

◆ **Personality - objective**
Personality
Individual

◆ **Intelligence**
Intellectual functioning
16-74
Performance on 10 subtests assessing various dimensions of intellectual functioning
Individual

◆ **Intelligence**
Intellectual functioning thought processes, ego functioning
06-17 years
Performance on 10 subtests assessing various dimensions of intellectual functioning
Individual

◆ **Intelligence**
Mental ability
Adult/Industry
Self assessment

◆ **Intelligence**
Intellectual functioning thought processes, ego functioning
04-6.5
Performance on 10 subtests assessing various dimensions of intellectual functioning
Individual

◆ **Intelligence**
Intellectual functioning, thought processes, ego functioning
05-15 years
Performance on 10 subtests assessing various dimensions of intellectual functioning
Individual

AS

Wechsler Adult Intelligence Scale (WAIS)

AS

Wechsler Intelligence Scale for Children (WISC)

AS

Wonderlic Personnel Test

AS

Wechsler Preschool and Primary Scale of Intelligence (WPPSI)

AS

Wechsler Preschool Primary Scale of Intelligence (WPPSI)

AS

Minnesota Multiphasic Personality Inventory (MMPI)

AS

16 PF

AS

California Psychological Inventory (CPI)

AS

Firo-B-Schutz

AS

Leary's Interpersonal Check List (ICL)

◆ **Intelligence**
Intelligence
11 to adult/gifted children/ cross cultural/mentally retarded
Individual

◆ **Intelligence**
Intelligence
Grades 3-12
Group

◆ **Intelligence**
Physical health, social adaptive behaviors socio-cultural background
Mentally retarded
Estimated learning potential
Individual

◆ **Intelligence**
02-Adult
Standard age scores with mean of 100 standard deviation of 16
Individual

◆ **Intelligence**
Mentally Retarded
Individual

◆ **Intelligence**
Ability to learn and adapt to semi-skilled jobs
Adult/Industry
Self assessment

◆ **Intelligence**
Intelligence
Grades K-12
Group

◆ **Intelligence**
Developmental level in a Piagetian model
4-7 Infant & Preschool
Piagetian scales
Individual

◆ **Intelligence**
Intelligence foresight & planning
03 & up /verbal/hearing impaired
Individual

◆ **Intelligence**
Intelligence
02.5 to adult/severely handicapped
Scales that correlate to other measures of intelligence
Individual

AS

Otis Self-Administered Test of Mental Ability

AS

Otis-Lennon School Ability Test

AS

Piagetian Scales

AS

Porteus Maze Test

AS

Peabody Picture Vocabulary Test - R (PPVT)

AS

Raven's Progressive Matrices (RPM)

AS

School and College Ability Tests (SCAT)

AS

System of Multicultural Pluralistic Assessment (SOMPA)

AS

Stanford Binet Intelligence

AS

System of Multicultural Pluralistic Assessment (SOMPA)

◆ **Intelligence**
Cross Cultural
Individual

◆ **Intelligence**
Fluid intelligence
02.5 to 12.5 years/preschool, minority & ethnic groups
Intellectual processing and acquired knowledge
Individual

◆ **Intelligence**
Intelligence Grades K-12
Verbal, Quantitative and Total scores
Group

◆ **Intelligence**
See WAIS-R

◆ **Intelligence**
Intellectual & motor functioning
02.5-8.5 years/Mentally retarded
8 subtests grouped into 6 overlapping scales - verbal, quantitative, perceptual-performance, general cognitive, memory, and motor.
Individual

◆ **Intelligence**

◆ **Intelligence**
03-15 years
Scales that correlate to other measures of intelligence
Individual

◆ **Intelligence**
Accuracy of observation and conceptual thinking
Cross Cultural
Scales that correlate to other measures of intelligence
Individual

◆ **Intelligence**
Used with the verbal scale of the WAIS
Blind
6 performance subtests
Individual

◆ **Intelligence**
Intelligence
Grades K-2, 3-6, 6-9, 9-12
Group

AS

Columbia Mental Maturity Scale

AS

Goodenough-Harris Drawing Test (G-HDT)

AS

Goodenough-Harris Drawing Test (G-HDT)

AS

Haptic Intelligence Scale for the Adult Blind

AS

Henmon-Nelson Tests of Mental Ability

AS

IPAT Culture Fair Intelligence Test

AS

Kaufman Assessment Battery (K-ABC)

AS

Kuhlmann-Anderson Tests of Mental Ability

AS

Multidimensional Aptitude Battery (MAB)

AS

McCarthy Scales of Children's Abilities (MSCA)

◆ **Intelligence**
Black
Individual

◆ **Intelligence**
Infant & Preschool
Individual

◆ **Intelligence**
Gross motor, fine motor
Mentally retarded
Age appropriate motor developmental level.
Individual

◆ **Intelligence**
Intelligence 03-12/ cerebral palsied children, speech and language or hearing loss
Scales that correlate to other measures of intelligence Individual

◆ **Intelligence**
Intelligence 03-12 years
Scales that correlate to other intelligence tests
Group

◆ **Infant Development**
General motor and cognitive development 01-18 mos.
Performance on developmental tasks
Individual

◆ **Intake**
Global functioning
Individual

◆ **Intelligence**
Ability to cope with the natural and social demands of the environment
03 & Mentally Retarded
Behavioral domains
Individual

◆ **Intelligence**
Intelligence 04.5 & above/deaf individuals
Individual

◆ **Intelligence**
Intellectual & motor functioning 02-30 months
Scales - Perception, memory, language, problem solving, verbal communication, abstract thinking, gross motor manipulatory skills of hands and fingers, emotional social and personality development.
Individual

AS

Cattell Infant Intelligence Scale

AS

Mental Status

AS

Adaptive Behavior Scale AAMD

AS

Arthur Point Scale of Performance Tests

AS

Bayley Scales of Infant Development

AS

Black Intelligence Test of Cultural Homogeneity

AS

Brazelton Neonatal Assessment Scale

AS

Brulninks-Oseretsky Test of Motor Proficiency

AS

Columbia Mental Maturity Scale (CMMS)

AS

Cognitive Abilities Tests

◆ **Career**
Career Assessment
Individual

◆ **Career Assessment**
Individual

◆ **Career Assessment**

◆ **Family Assessment**
Family dynamics
Family

◆ **Family Assessment**
Family process and problem solving ability
Interpersonal, family structure, communication
Family

◆ **Individual**

◆ **Career**
Career interests and skill levels
Match to others in fields they enjoy.
Individual

◆ **Career**
Individual

◆ **Career Assessment**

◆ **Career Assessment**
Individual

AS

Self Directed Search

AS

Strong-Campbell

AS

Work Value Inventory

AS

California Occupational Preference System

AS

Jackson Vocational Interest Survey

AS

Kuder Occupational Interest Survey

AS

Ohio Vocational Interest Survey

AS

Vocational Preference Inventory

AS

Structured Family Interview

AS

Wilt Wyck Family Task

◆ **Career**
Individual

◆ **Career**
Individual

◆ **Career**

◆ **Career**

◆ **Career**
Individual

◆ **Aptitude**
Occupational
Individual

◆ **Aptitude**
Individual

◆ **Aptitude**
Occupational
Individual

◆ **Aptitude**
Individual

◆ **Behavioral Assessment**
Individual or Group

AS

Mechanical Aptitude Tests

AS

Musical Aptitude Profile

AS

Psychomotor Ability Tests

AS

Purdue Peg Board

AS

Behavioral Observations

AS

Career Ability Placement Survey (CAPS)

AS

Career Orientation Placement and Evaluation Survey (COPES)

AS

Cops Interest Inventory

AS

Differential Aptitude Test (DAT)

AS

Minnesota Importance Questionnaire

◆ **Achievement**

◆ **Aptitude**
Individual

◆ **Aptitude**
Individual

◆ **Aptitude**
Individual

◆ **Aptitude**
Individual

◆ **Achievement**
Individual

◆ **Achievement**
Individual

◆ **Achievement**
Individual

◆ **Achievement**
Individual

◆ **Achievement**
Individual

AS

California Achievement Tests

AS

Graduate Record Exam (GRE)

AS

Iowa Tests of Basic Skills

AS

Miller Analogies Test

AS

Scholastic Aptitude Test (SAT)

AS

Stanford Achievement Test

AS

Aptitude Test

AS

Differential Aptitude Test (DAT)

AS

Flanagan Tests Fact

AS

General Aptitude Test
Battery (GATB)

- Higher incidence of:
  Medical illnesses, physical deformities,
  developmental delays,
  hyperactivity, hypervigilence, aggression, disobedience, anti-social behavior,
  fear, withdrawal, immaturity, low self-esteem,
  seductiveness, exhibitionism, sexualized behavior,
  PTSD

- May show:
  Poor impulse control, low frustration tolerance
  Emotional over-reactivity
  High authoritarianism, rigidity
  Drug & alcohol abuse
  Socially isolated
  Low self-esteem
  High need for control
  See children as "property"

- Protection: Medication &/or Hospitalization
- Short-term cognitive - behavioral: identify depressogenic thoughts; create viable substitutes
- Longer-term psychodynamic - active engagement, uncover unconscious suicidal fantasies; resolve recent & early life losses
- Use team approach

- No accurate method of prediction
- Best indicator - previous gesture(s)
- Key issues in assessing risk:
  elevated agitation
  constriction
  lethality of intent (plan)
- "Contracting" is an assessment tool, not an intervention

- Aging affects whole person
- Special issues: sexuality, numerous losses, depression, suicidality, death & dying
- Therapist needs to be aware of own issues re: aging, death & dying

- Includes verbal, emotional & physical abuse
- Widespread scope
- Leading cause of harm to women ages 15-44 yrs.
- Primary perpetrators are male
- Characteristics: externalize blame, use force, abuse drugs &/or alcohol, labile moods; often have paranoid, narcissistic, borderline, anti-social personality

- Awareness of effects of discrimination
- Special issues:
  Absence of role models
  Identity issues & "coming out", "being out" & being "closeted"
- Homophobia in society & in therapists
- Multiple oppressions: special issues of minority groups and sexual orientation

- Awareness of diversity
- Respect for and knowledge of differences
- Awareness of effects of prejudice
- Need for validation of discriminatory experience(s)
- Awareness of appropriate community supports

- Effects of sexism on counseling: gender biases in diagnosis, differences in assessment of what is healthy
- Self-esteem issues related to traditional gender roles
- "New" bias in preference for androgynous clients
- Feminist therapy includes socio-cultural context of women's roles

- Phases of adaptation to traumatic disability & loss: shock, anxiety, denial, depression, internalized anger, externalized hostility, acknowledgement & adjustment
- Focus on affect in early stages of adaptation
- Cognitive-behavioral & active-directive approaches in later stages

ST

Characteristics of Abusive Parents

ST

Characteristics of the Abused Child

ST

Suicide: Assessment

ST

Suicide: Treatment

ST

Domestic Violence

ST

Counseling Elderly Clients

ST

Counseling Minority Group Clients

ST

Counseling Lesbian & Gay Clients

ST

Counseling Clients with Physical Disabilities

ST

Gender Issues in Counseling

- Long-standing, deeply ingrained, ego-syntonic maladaptive behaviors, thoughts, feelings
- Cluster A - Odd suspicious, eccentric:
  - Paranoid Personality Disorder - distrust and suspiciousness
  - Schizoid Personality Disorder - detachment from social relationships, restricted emotional expression
  - Schizotypal Personality Disorder - great discomfort in social relationships; eccentric; distortions

- Clinically significant emotional or behavioral symptoms in response to specific stressor
- Symptoms develop within 3 months & resolve within 6 months of termination of stressor
  - Adjustment Disorder:
    - With Depressed Mood
    - With Anxiety
    - With Mixed Anxiety & Depressed Mood
    - With Disturbance of Conduct
    - With Mixed Disturbance of Emotions & Conduct

- Long-standing, deeply ingrained, ego-syntonic maladaptive behaviors, thoughts, feelings
- Cluster C - Anxious, fearful, indirect:
  - Avoidant Personality Disorder - extreme social inhibition; feelings of inadequacy; fear of negative evaluation
  - Dependant Personality Disorder - Excessive need to be taken care of; submissive, clingy behavior
  - Obsessive-Compulsive Personality Disorder - preoccupation with orderliness, perfection & control
  - Personality Disorder NOS

- Long-standing, deeply ingrained, ego-syntonic maladaptive behaviors, thoughts, feelings
- Cluster B - Dramatic, emotional, erratic:
  - Antisocial Personality Disorder - Disregard for, violation of others
  - Borderline Personality Disorder - Instability in relationships, self-image, affect; impulsivity
  - Histrionic Personality Disorder - excessive emotionality & attention seeking
  - Narcissistic Personality Disorder - grandiosity, extreme need for admiration; lack of empathy

Neuroleptic-Induced Parkinsonism
Neuroleptic Malignant Syndrome
Neuroleptic-Induced Acute Dystonia
Neuroleptic-Induced Acute Akathisia
Neuroleptic-Induced Tardive Dyskenisia
Medication-Induced Postural Tremor
Medication-Induced Movement Disorder NOS
Adverse Effects of Medication NOS

- Mental Disorder Affecting . . . (GMC)
- Personality Traits Affecting . . . (GMC)
- Maladaptive Health Behaviors Affecting . . . (GMC)
- Stress-Related Physiological Response Affecting . . . (GMC)
- Other or Unspecified Factors Affecting . . . (GMC)

- V Codes:
  - Relational Problem Related to a Mental Disorder or General Medical Condition
  - Parent-Child Relational Problem
  - Partner Relational Problem
  - Sibling Relational Problem
  - Relational Problem NOS

- Other problems that can be a focus of clinical attention that do not meet the criteria for a mental disorder:
  - Relational Problems
  - Problems Related to Abuse or Neglect
  - Additional Conditions That May Be a Focus of Clinical Attention

- V Codes:
  - Non-Compliance with Treatment
  - Malingering
  - Adult Antisocial Behavior
  - Borderline Intellectual Functioning (AxisII)
  - Age-Related Cognitive Decline
  - Bereavement
  - Academic Problem
  - Occupational Problem
  - Identity Problem
  - Religious or Spiritual Problem
  - Acculturation Problem
  - Phase of Life Problem

- V Codes:
  - Physical Abuse of a Child
  - Sexual Abuse of a Child
  - Neglect of a Child
  - Physical Abuse of Adult
  - Sexual Abuse of Adult
- These are coded (995. . . . when focus is on the victim)

DX

Adjustment Disorders

DX

Personality Disorders
Cluster A:
Odd, Suspicious, Eccentric Group

DX

Personality Disorders
Cluster B:
Dramatic, Emotional, Erratic,
Egocentric Group

DX

Personality Disorders
Cluster C:
Anxious, Fearful, Indirect Group

DX

Psychological Factors Affecting Medical Condition

DX

Medication-Induced Movement Disorders

DX

V Codes

DX

Relational Problems

DX

Problems Related to Abuse or Neglect

DX

Additional Problems That May Be a Focus of Clinical Attention

- Actual or perceived physical symptoms not explained by a GMC or substance, or another mental disorder

Somatization Disorder
Undifferentiated Somatoform Disorder
Pain Disorder with Psychological Factors
Hypochondriasis
Body Dysmorphic Disorder
Somatoform Disorder NOS

Panic Disorder Without Agoraphobia
Panic Disorder With Agoraphobia
Agoraphobia Without History of Panic Disorder
Specific Phobia
Social Phobia
Obsessive-Compulsive Disorder
Post Traumatic Stress Disorder
Acute Stress Disorder
Generalized Anxiety Disorder
Anxiety Disorder Due to . . . (GMC)
Substance-Induced Anxiety Disorder
Anxiety Disorder NOS

- Disruptions of the integrated functions of memory, consciousness, identity &/or perceptions of the environment

Dissociative Amnesia
Dissociative Fugue
Dissociative Identity Disorder (formerly Multiple Personality Disorder)
Depersonalization Disorder
Dissociative Disorder NOS

- Intentionally produced or feigned physical or psychological symptoms

Factitious Disorder With Predominantly Psychological Signs & Symptoms
Factitious Disorder With Predominantly Physical Signs & Symptoms
Factitious Disorder With Combined Psychological & Physical Signs & Symptoms
Factitious Disorder NOS

- Recurrent, intense sexual urges and sexually arousing fantasies of non-human objects, children or non-consenting persons

Exhibitionism
Fetishism
Frotterism
Pedophilia
Sexual Masochism
Sexual Sadism
Transvestic Fetishism
Voyeurism
Paraphilia NOS

- Disturbances in sexual desire and sexual response cycles

Hypoactive Sexual Desire Disorder
Sexual Aversion Disorder
Female Sexual Arousal Disorder
Male Erectile Disorder
Female Orgasmic Disorder
Male Orgasmic Disorder
Premature Ejaculation
Dyspareunia
Vaginismus
Sexual Dysfunctions Due To . . . (GMC)

- Anorexia Nervosa: refusal or inability to maintain normal weight for one's age & height; 15% decrease in body weight; can contain binge eating/purging episodes within larger restrictive eating pattern; failure to menstruate
- Bulemia Nervosa: recurrent episodes of binge eating with purging, or fasting, or excessive exercise
- Eating Disorder NOS

- Strong, persistent identification with the opposite sex
- Discomfort with one's assigned sex or sense of inappropriateness in that gender role

Gender Identity Disorder in Children
Gender Identity Disorder in Adolescents and Adults
Gender Identity Disorder NOS

- Failure to resist an impulse, drive or temptation or to perform an act harmful to self or others

Intermittent Explosive Disorder
Kleptomania
Pyromania
Pathological Gambling
Trichotillomania
Impulse Control Disorder NOS

- Severe disturbances in sleeping

Dyssomnias
  Primary Insomnia
  Primary Hypersomia
  Narcolepsy
  Breathing-Related Sleep Disorder
  Circadian Rhythm Sleep Disorder
  Dyssomnia NOS
Parasomnias
  Nightmare Disorders
  Sleep Terror Disorder
  Sleep walking Disorder; Parasomnia NOS

DX

Anxiety Disorders

DX

Somatoform Disorders

DX

Factitious Disorders

DX

Dissociative Disorders

DX

Sexual Dysfunction Disorders

DX

Paraphilias

DX

Gender Identity Disorders

DX

Eating Disorders

DX

Sleep Disorders

DX

Impulse Control Disorders
Not Elsewhere Classified

- Marked social, cognitive and occupational dysfunction
- Marked impairment of reality testing
  Disorganized Type
  Catatonic Type
  Paranoid Type
  Residual Type
  Undifferentiated Type

- Dependence - symptoms indicating continued substance use despite significant substance-related problems
- Abuse - recurrent maladaptive pattern with significant adverse consequences related to substance use
- Specifiers: remission, agonist therapy, physiological dependence, in a controlled environment
- Disorders: (Substance) - Dependence, Abuse, Intoxication, Withdrawal, Delirium, Dementia, Mood, Psychotic, Anxiety, Sexual Dysfunction, Sleep - Disorder

- Schizophrenic symptoms concurrent with a Major Depressive, Manic or Mixed Episode

- Schizophrenic symptoms with duration less than 6 months
- Social & occupational dysfunction not necessarily present

- Brief Psychotic Disorder - symptoms: 1 day - 1 month
- Shared Psychotic Disorder - Folie a Deux
- Psychotic Disorder Due To—(GMC)
- Substance Induced Psychotic Disorder

- 1 or more non-bizarre delusions - at least 1 month

- Major Depressive - 1 or more major depressive episodes with depressed mood & other symptoms for at least two weeks
- Dysthymic - 2 years of depressed mood, but not meeting criteria for Major Depressive Episode

- Major Depressive Disorder
- Dysthymic Disorder
- Bipolar Disorders
- Other Mood Disorders

- Mood Disorder Due To—(GMC)
- Substance-Induced Mood Disorder
- Mood Disorder NOS

- Bipolar I - 1 or more Manic or Mixed Episodes usually with Major Depressive Episode
- Bipolar II - recurrent Major Depressive Episodes with one or more Hypomanic Episodes
- Cyclothymic Disorder - 2 years of numerous periods of hypomanic & depressive symptoms that don't meet criteria for Major Depressive Episode
- Bipolar Disorder NOS

DX

Substance-Related Disorders Concepts

DX

Schizophrenic Disorders

DX

Schizophreniform Disorder

DX

Schizoaffective Disorder

DX

Delusional Disorder

DX

Psychotic Disorders

DX

Mood Disorders

DX

Depressive Disorders

DX

Bi-Polar Disorders

DX

Other Mood Disorders

- Broad based, pervasive impairment in social interaction skills, communication skills, not generally expected for child's age; and/or
- Presence of stereotyped behavior, interests or activities
    - Autistic Disorder
    - Rett's Disorder
    - Childhood Disintegrative Disorder
    - Asperger's Disorder
    - Pervasive Developmental Disorder NOS

- Impairment in communication functioning as demonstrated by scores on standardized, individually administered measures
    - Expressive Language Disorder
    - Mixed Expressive-Receptive Language Disorder
    - Phonological Disorder
    - Stuttering
    - Communication Disorder NOS

- Persistent feeding and eating disturbances including eating inappropriate substances, frequent regurgitating and rechewing
- Failure to gain appropriate weight
    - Pica
    - Rumination Disorder
    - Feeding Disorder of Infancy or Early Childhood

- Persistent disruptive, self-injurious, socially unacceptable &/or environmentally destructive behavior
- Some symptoms must be present before 7 years
    - ADHD Combined Type
    - ADHD, Predominantly Inattentive
    - ADHD, Hyperactive-Impulsive Type
    - ADHD NOS
    - Conduct Disorder
    - Oppositional Defiant Disorder
    - Disruptive Behavior Disorder NOS

- Elimination of urine or feces at inappropriate times &/or places
    - Encopresis With Constipation & Overflow Incontinence
    - Encopresis Without Constipation & Overflow Incontinence
    - Enuresis

- Sudden, rapid, recurrent stereotyped movement or vocalization
    - Tourette's Disorder
    - Chronic Motor or Tic Disorder
    - Transient Tic Disorder
    - Tic Disorder NOS

- Multiple deficits in cognition or memory
- Significant change from previous level of functioning
- Etiology - general medical condition &/or substance abuse

- Diverse group; Persistent disorders
    - Separation Anxiety Disorder
    - Selective Mutism
    - Reactive Attachment Disorder of Early Infancy or Childhood
    - Stereotypic Movement Disorder

Alcohol-Related Disorders
Amphetamine-Related Disorders
Caffeine-Related Disorders
Cannabis-Related Disorders
Cocaine-Related Disorders
Hallucinogen-Related Disorders
Inhalant-Related Disorders
Nicotine-Related Disorders
Opioid-Related Disorders
Phenocyclidine-Related Disorders
Sedative, Hypnotic, or Anxiolitic-Related Disorders
Polysubstance-Related Disorder
Other (or Unknown) Substance-Related Disorder

- Mental Symptoms that are a direct physiological consequence of a medical condition
    - Catatonic Disorder Due To. . . .
    - Personality Change Due To . . .
    - Mental Disorder NOS Due To . . .

DX

Communication Disorders

DX

Pervasive Developmental Disorders

DX

Attention Deficit & Disruptive Behavior Disorders

DX

Feeding & Eating Disorders of Infancy or Early Childhood

DX

Tic Disorders

DX

Elimination Disorders

DX

Other Disorders of Infancy, Childhood or Adolescence

DX

Delerium, Dementia, Amnestic & Other Cognitive Disorders

DX

Mental Disorders Due to a General Medical Condition not Elsewhere Classified

DX

Substance-Related Disorders

- Personality Disorders
- Mental Retardation
- Can also include personality traits, defense mechanisms

- Clinical Syndromes
- Other Conditions That May Be a Focus of Treatment
- Can be more than one
- First listed is primary focus of treatment

- Psychosocial & environmental problems
- List of current stressors

- Must be diagnosed by a physician
- Must have an ICD-9-CM or ICD-10-CM code
- Axis III Provisional is used until medical diagnosis is confirmed

- Narrative summary related to cultural identity
- Cultural factors effecting psychosocial environment, diagnosis, treatment, and/or the relationship between client & clinician

- Clinician's judgment of overall functioning
- Assesses client's coping and resources
- Used for treatment planning and prognosis
- Current level of functioning only

- Below average intellectual functioning
- Onset before age 18
- Concurrent deficits or impairments in adaptive functioning
  Mild - IQ 50-55 to 70
  Moderate - IQ 35-40 to 50-55
  Severe - IQ 20-25 to 35-40
  Profound - IQ below 20
  Mental Retardation, Severity Unspecified

- Mental Retardation - Axis II
- All others - Axis I:
  Learning Disorders
  Motor Skills Disorders
  Communication Disorders
  Pervasive Developmental Disorders
  Attention Deficit & Disruptive Behavior Disorders
  Feeding and Eating Disorders of Infancy or Early Childhood
  Tic Disorders
  Elimination Disorders
  Other Disorders of Infancy, Childhood & Adolescence

- Marked impairment in the development of motor coordination

- Achievement on standardized tests is substantially below expectation for age, schooling and level of intelligence
  Reading Disorder
  Mathematics Disorder
  Disorder of Written Expression
  Learning Disorder Not Otherwise Specified

DX

DSM IV
Axis I

DX

DSM IV
Axis II

DX

DSM IV
Axis III

DX

DSM IV
Axis IV

DX

DSM IV
Axis V

DX

DSM IV
Cultural Formulations

DX

Disorders of Infancy
Childhood & Adolescence

DX

Mental Retardation

DX

Learning Disorders

DX

Motor Skills Disorder

- The number above or below which a statistic is significant

- The probability of making a type I error - of rejecting the null hypothesis when it is true
- Set by researcher, usually at .05 or .01 in behavioral research

- Alpha
- Occurs when the researcher rejects a true null hypothesis when it is correct
- As the value of alpha increases the probability of a type I error increases

- The number of values or categories in a distribution that are free to vary
- Certain values or categories in the distribution are fixed

- Quantify the degree of relationship or correlation between variables

- Beta
- Occurs when the researcher retains a false null hypothesis when it is false
- As the probability of making a type I error increases, the probability of making a type II error decreases and vice versa

- Refers to a test's usefulness
- Test is valid when it measures what it is presumed to measure

- The accuracy of the test
- Internal consistency, alternate forms, test-retest
- The longer the test, the better the reliability

- Extent to which statistics vary from the true population parameters
- May be due to systematic factors or random factors
- The smaller the sample the greater the sampling error

- Nominal data - Chi Square
- Ordinal data - Mann Whitney, Wilcoxen
- Interval & ratio data - t-test, ANOVA ANCOVA, and Post Hoc tests for ANOVA

RS

Significance Level
(Value of Alpha)

RS

Critical Value

RS

Degrees of Freedom (DF)

RS

Type I Error

RS

Type II Error

RS

Descriptive Measures

RS

Reliability

RS

Validity

RS

Inferential Statistical Tests

RS

Sampling Error

- Measure of variability
- Indicates how scores differ from one another

- Simplest measure of variability
- Subtract lowest score from highest score

- References an individual score to all other scores in the distribution
- Obtained by converting individual scores to a percentage of observations that fall below that score

- Measure of variability in relation to the mean

- Standard scores are expressed in standard deviation units
- The mean is always zero, and the standard deviation is always one
- Most widely used standard score

- An observation expressed in standard deviation units from the mean
- Has a known and constant mean and standard deviation

z-scores & t-scores

- Allows researcher to make inferences about the relationship between independent and dependant variables in samples drawn from the population

- Most commonly used standard score for reporting performance
- Gives same information as z-scores, but uses only positive numbers
- Mean is always 50; SD is always 10

- Statistical hypothesis that states the opposite of the null hypothesis
- Usually predicts there is a relationship between variables

- Statistical hypothesis stating that no relationship exists between the variables - assumption made that any difference found due to sampling error

RS

Range

RS

Variance

RS

Standard Deviation

RS

Percentile Ranks

RS

Standard Score

RS

Z - Scores

RS

t - Scores

RS

Inferential Statistics

RS

Null Hypothesis

RS

Alternative Hypothesis

- Information ranked greatest to least
- Used with rank order data
- Intervals between categories not the same

- Distinguishes groups
- Does not reflect differences in magnitude

- Allows comparisons between measurements
- Magnitudes of intervals are equal
- Has absolute zero point

- Allows comparisons between measurements
- Zero point is arbitrary
- Magnitudes of intervals are equal

- Score that divides a set of data in half when the data is ordered from lowest to highest

- Score that occurs most often in a set of data

- Used when sample is randomly obtained and scores normally distributed about the mean
- t-test or ANOVA

- Balance point of a set of scores
- Used in advanced statistical calculations
- Sensitive to extreme scores

- Indicates distribution of the scores
- Range, Variance & Standard Deviation

- Used when there is no assumption about the shape or variance of scores
- No assumption can be made that data is normally distributed

RS

Nominal Scale

RS

Ordinal Scale

RS

Interval Scale

RS

Ratio Scale

RS

Mode

RS

Median

RS

Mean (Arithmetic Mean)

RS

Parametric Statistics

RS

Non-Parametric Statistics

RS

Measures of Variability (Dispersion)

- Focus on underlying issues
- Usually psychodynamically oriented
- Thoughts & feelings are the primary focus
- Not time limited

- Time limited sessions (10-15)
- Focus on current problems
- Behaviorally &/or cognitively oriented
- Avoidance of transference, dependency, regression
- Active therapist role

- Mediation between two or more disputing parties
- Mediator acts as facilitator
- Disputing parties determine mutually agreeable solutions

- Response to a specific precipitant
- Goal: reduce stress and restore functioning
- Goal: development of adaptive coping skills for future situations

- Behavior modification
- Play therapy
- Techniques: structured, active counseling use of props, games, pictures
- Work with family
- Medication used in some instances

- Behavior modification
- Work with family and teachers
- Modified counseling techniques: structured, active and directive
- Focus on self-esteem, interpersonal relations and self-care

- Cognitive therapy used in package plan: education, group counseling, participation in AA/NA, family counseling
- Individual counseling often necessary
- Psychodynamic therapy to deal with feelings

- Primary treatment provider usually neurologist and/or psychiatrist
- Cognitive therapy: structured treatment re: coping with memory loss
- Psychodynamic therapy: dealing with associated emotional losses
- Medication may be prescribed

- Behavioral & cognitive: desensitization, thought stopping, relaxation, & other cognitive techniques
- Psychodynamic
- Medical: anti-anxiety, anti-depressant medications

- Cognitive-Behavioral, Psychodynamic, Interpersonal: clients with mild or moderate symptoms
- Psychotherapy & medication used with severely depressed and bi-polar disorders

TP

Brief Treatment

TP

Moderate/Long Term Treatment

TP

Crisis Intervention

TP

Conflict Resolution

TP

Treatment Planning:
Mental Retardation

TP

Treatment Planning:
Child & Adolescent Disorders

TP

Treatment Planning:
Cognitive Disorders

TP

Treatment Planning:
Substance-Related Disorders

TP

Treatment Planning:
Mood Disorders

TP

Treatment Planning:
Anxiety Disorders

- Stucturalist theorist: Cognitive development achieved through assimilation, accommodation, & equilibration
- Stages of operational thought

- Cognitive development theorist
- Information processing theory
- Quantitative changes in thinking
- Skills acquired through learning & experience

- Psychoanalytic Theory
- Instinctual drives determine personality development
- Personality - Id, ego, superego
- Oral, anal, phallic, latency, genital phases

- Language the key to development
- Enactive, Iconic, symbolic stages of cognitive development

- Neo-Freudian
- Adlerian Psychology
- Behavior occurs in social context
- Emphasis on "becoming"

- Neo-Freudian
- Psychosocial development theorist
- Stages through maturity with central life tasks

- Analytical Psychology
- Importance of symbolism
- Archetypes, collective unconscious

- Neo-Freudian
- Influence of culture on personality
- Focus on psychology of women
- Concept of self is central

- Self-actualization theorist
- Self-actualization highest level of ego development
- Peak experiences

- Object relations theorists
- Dynamics between self and object representations

GP

Roger Gagne

GP

Jerome Bruner

GP

Erik Erikson

GP

Karen Horney

GP

Althea Horner
Otto Kernberg

GP

Jean Piaget

GP

Sigmund Freud

GP

Alfred Adler

GP

Carl Jung

GP

Abraham Maslow

- Moral development theorist
- Gender differences in morality
- Study of women's morality - based on relationships

- Moral development theorist
- Stages/levels of morality each more complex than previous stage
- Relationship between self & society

- Imprinting phenomenon
- Adaptive function - keeps young close to mother

- Monkeys with surrogate mothers
- Attachment problems lead to social difficulties

- Anaclitic depression
- Hospitalisms

- Attachment & separation
- Stranger anxiety
- Separation anxiety

- Death & dying
- Stages of dying

- Stages of adult life cycle

- Ego Psychologists
- Ego-defensive functions
- Ego-autonomous functions

- Interpersonal psychotherapy
- Therapist as active participant/observor

GP

Lawrence Kohlberg

GP

Carol Gilligan

GP

Harry Harlow

GP

Konrad Lorenz

GP

John Bowlby

GP

Renee Spitz

GP

David Levinson

GP

Elizabeth Kubler-Ross

CT

Harry Stack Sullivan

CT

Anna Freud
Heinz Hartmann
David Rappaport

- Cognitive, Reality & Medical therapy
- Work with physician to focus on stressors, provide support, development of effective stress management and coping mechanisms

- Combination of Psychodynamic, Psycho-educational, Group and Medical therapy
- Work with physician on physical symptoms and the relationship to emotional problems

- Behavioral, Cognitive and Reality Therapy
- Focus on relational problems, and consequences of behavior
- Medical intervention may be needed with some sexual dysfunctions

- Psychodynamic, Cognitive, Behavioral, Hypnosis, Family and Medical therapies
- Anxiety management, and exploration of precipitating and/or original trauma
- Family work particularly with child clients

- Behavioral, Cognitive, Psychodynamic, Medical Behavior shaping and other structured procedures
- Address underlying anxiety or stress
- Some conditions need medical treatment

- Behavioral, Cognitive, Group, Psychodynamic, Medical
- Work closely with physician
- Group therapy needs a strong leader
- In-patient treatment may be necessary

- Crisis Intervention, Psychodynamic, Cognitive and Psycho-educational
- Work with precipitating event(s)
- Develop new resources and support systems, and new coping methods
- Improve decision making

- Behavioral, Reality Therapy, Psycho-educational and Group
- Goal setting: reward/punishment programs
- Teach new behaviors
- Feedback oriented

- Medical, Cognitive and Psychodynamic
- Medication is primary mode of treatment
- Individual therapy is supportive
- Deal with issues of daily life
- Family work
- Major anti-psychotic medications used

- Behavioral, Psycho-educational, Psychodynamic, Group, Family, Adjunctive Services
- Levels of treatment:
  1. Deal with presenting problem—therapy is active, structured and concrete
  2. Psychodynamic—dealing with underlying personality issues
- Medications sometimes used

TP

Treatment Planning:
Somatoform Disorders

TP

Treatment Planning:
Dissociative Disorders

TP

Treatment Planning:
Eating Disorders

TP

Treatment Planning:
Impulse Control Disorders

TP

Treatment Planning:
Personality Disorders

TP

Treatment Planning:
Factitious Disorders

TP

Treatment Planning:
Sexual & Gender
Identity Disorders

TP

Treatment Planning:
Sleep Disorders

TP

Treatment Planning:
Adjustment Disorders

TP

Treatment Planning:
Psychotic Disorders

- Behavioral theorist
- Operant conditioning (behavior shaping)

- Rational Emotive Therapy (RET)
- Examines cause and effect beliefs: Anxiety caused by irrational beliefs

- Humanistic Psychotherapy
- Person Centered Therapy: Empathy, non-judgmental understanding

- Transactional Analysis (TA)
- "Child", "Parent", "Adult" Ego states
- Motivated by need for strokes (recognition)
- Life scripts; rigid stereotyped games

- Cognitive Psychotherapy
- Detailed thought analysis
- Restructure thinking patterns

- Behavior therapist
- Classical conditioning principles applied to therapy
- Eliminate maladaptive behavior
- No underlying causes postulated

- Social learning theorist
- Behavior under control of certain stimuli and certain reinforcers

- Humanistic Psychotherapy
- Gestalt Therapy
- Here-and-now focus
- Immediate awareness of experience

- Reality Therapy
- Focus on accurate self perception
- Personal responsibility: face reality without harm to self or others

- Existential Psychotherapist
  Experiential Psychotherapy

GP

Joseph Wolpe

GP

Albert Bandura

CT

Fritz Perls

CT

William Glasser

CT

Eugene Gendlin

GP

B.F. Skinner

CT

Albert Ellis

CT

Carl Rodgers

CT

Eric Berne

CT

Aaron Beck

CLINICAL MENTAL HEALTH COUNSELOR

Flashcards

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476

CLINICAL MENTAL HEALTH COUNSELOR

Crossword Puzzles

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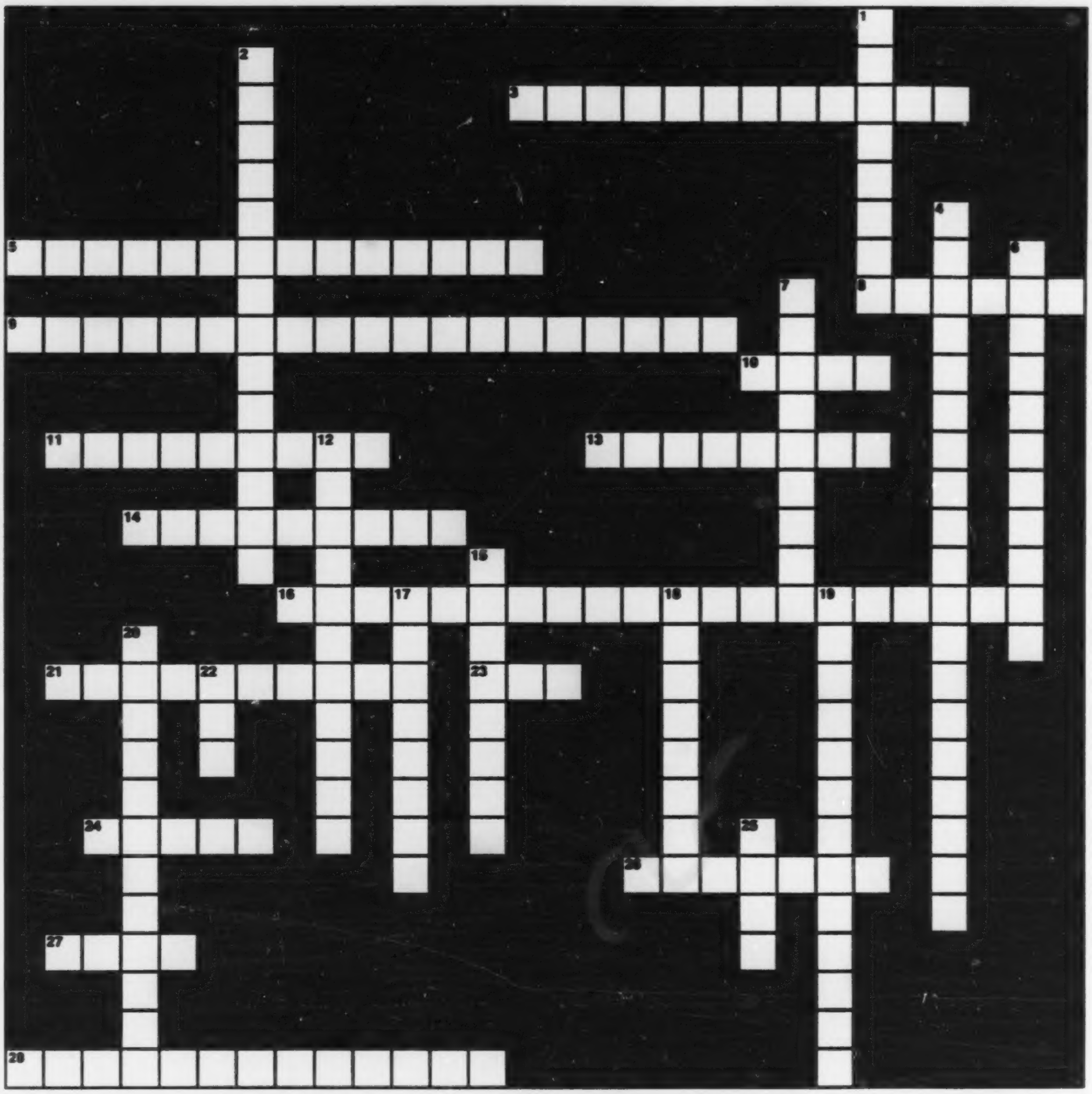
Assessment 1



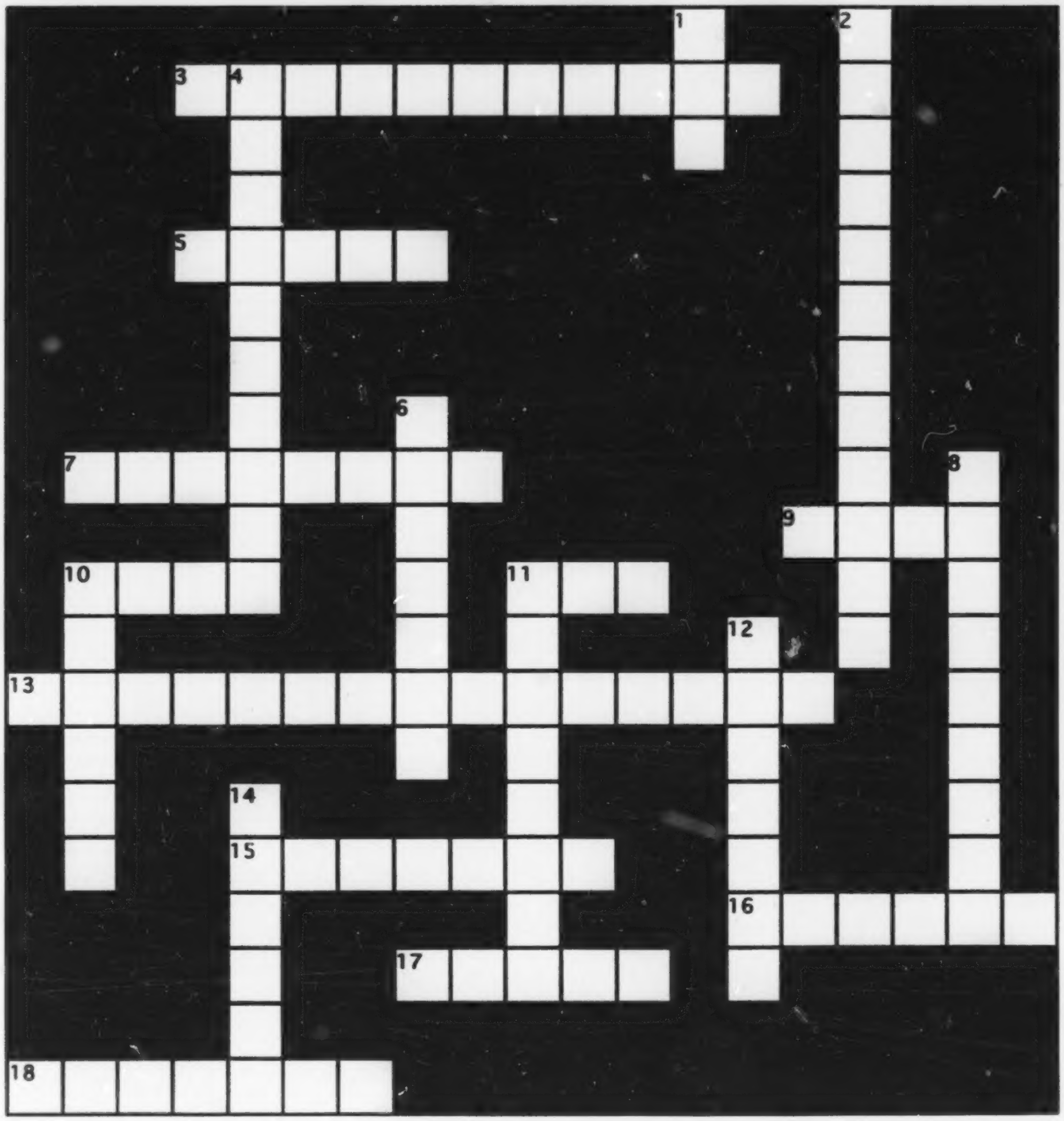
Across

3 Global mental capacity
5 One of the more well known career tests that can be computer scored
8 When creating a behavioral plan this is the behavior that is to be changed
9 Assessment instrument provided during the learning process
10 An inventory with three validity scales L, F & K
11 A scale used for infants and preschoolers
13 A test for the mentally retarded
14 One of the better known projective tests
16 Objective measure of "stream of behavior"
21 What happens before a behavior
23 Made up of 29 pictures and one blank card
24 Created the structured family interview
26 A test used for the handicapped
27 R=intelligence test for ages 16-74
28 Used for clients with brain dysfunction

Down

1 Objective and subjective methods for assessing family groups
2 Unstructured interpretation of an image or task
4 Measure of task or situational activity
6 Emotional, motivational, interpersonal and attitudinal characteristics of an individual
7 An evaluation provided at the end of a test
12 A measure of an individuals degree of mastery in a specific subject or task area
15 Created a family assessment that consists of eight tasks
17 Measures a narrower range of capabilities than an achievement test
18 The Purdue Pegboard is an ____________ test
19 Intelligence Test
20 Fixed apparatus or equipment used in testing
22 An inventory used with ages 14 to adult in many settings
25 One of the first personality assessments, used by the military

Career



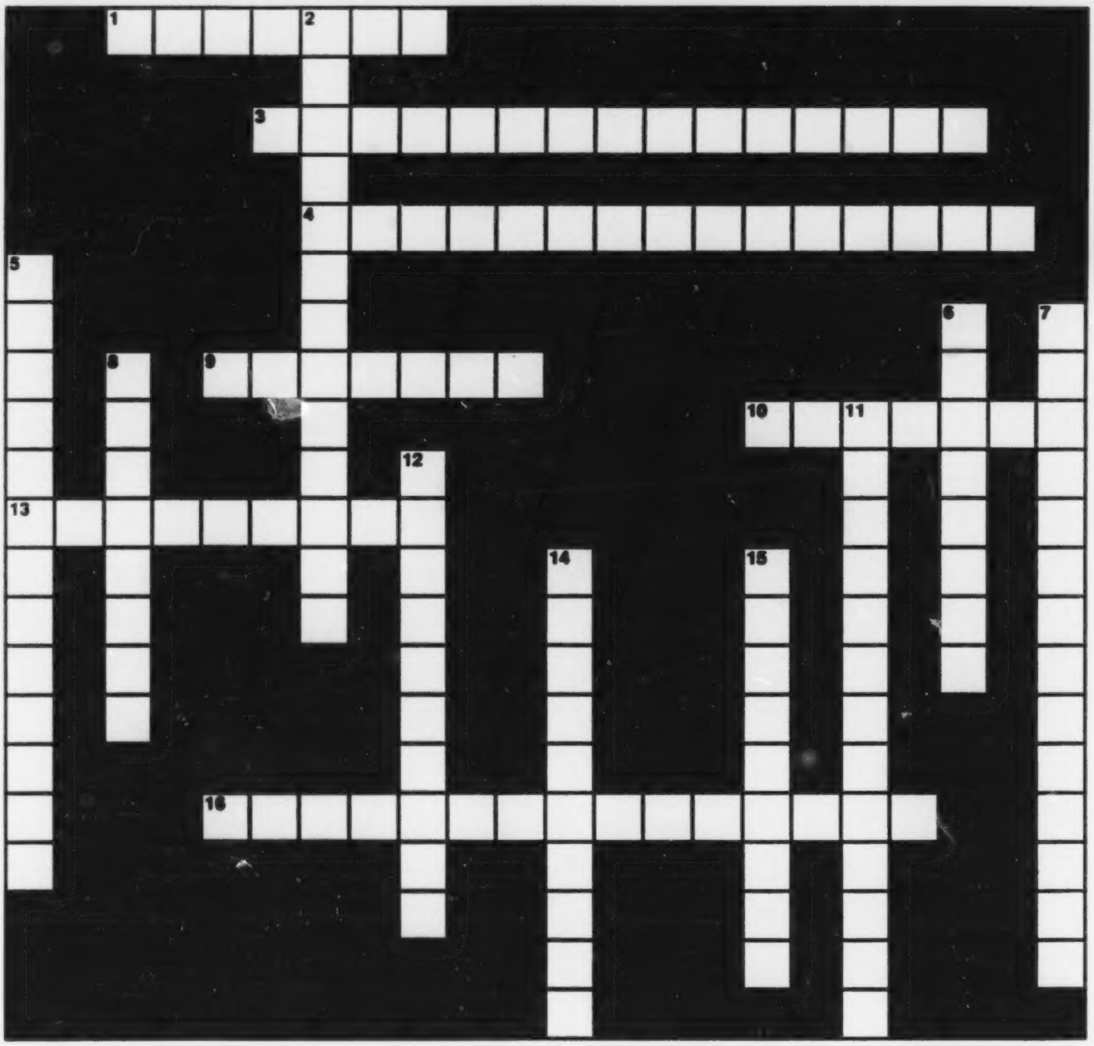
Across

3 Developmental
5 Developmental stages & Vocational developmental tasks
7 H. B. Gelatt
9 System of interactive guidance and information files
10 Coordinated occupational information network
11 Guidance information system
13 Becoming unique or different
15 Trait factoring
16 A series of jobs and occupations
17 Computer linked exploration of careers and training
18 Developmentalist

Down

1 A person in a position doing a set of tasks
2 Consultation, counseling, implementation, assessment, information, administration
4 A definable work activity found in many locations
6 Personality based
8 A person's orientation and preference in regard to career, family & leisure
10 Comprehensive model
11 Helping people understand and act on their knowledge of work
12 Needs approach
14 Potential for self improvement

Counseling Theories



Across

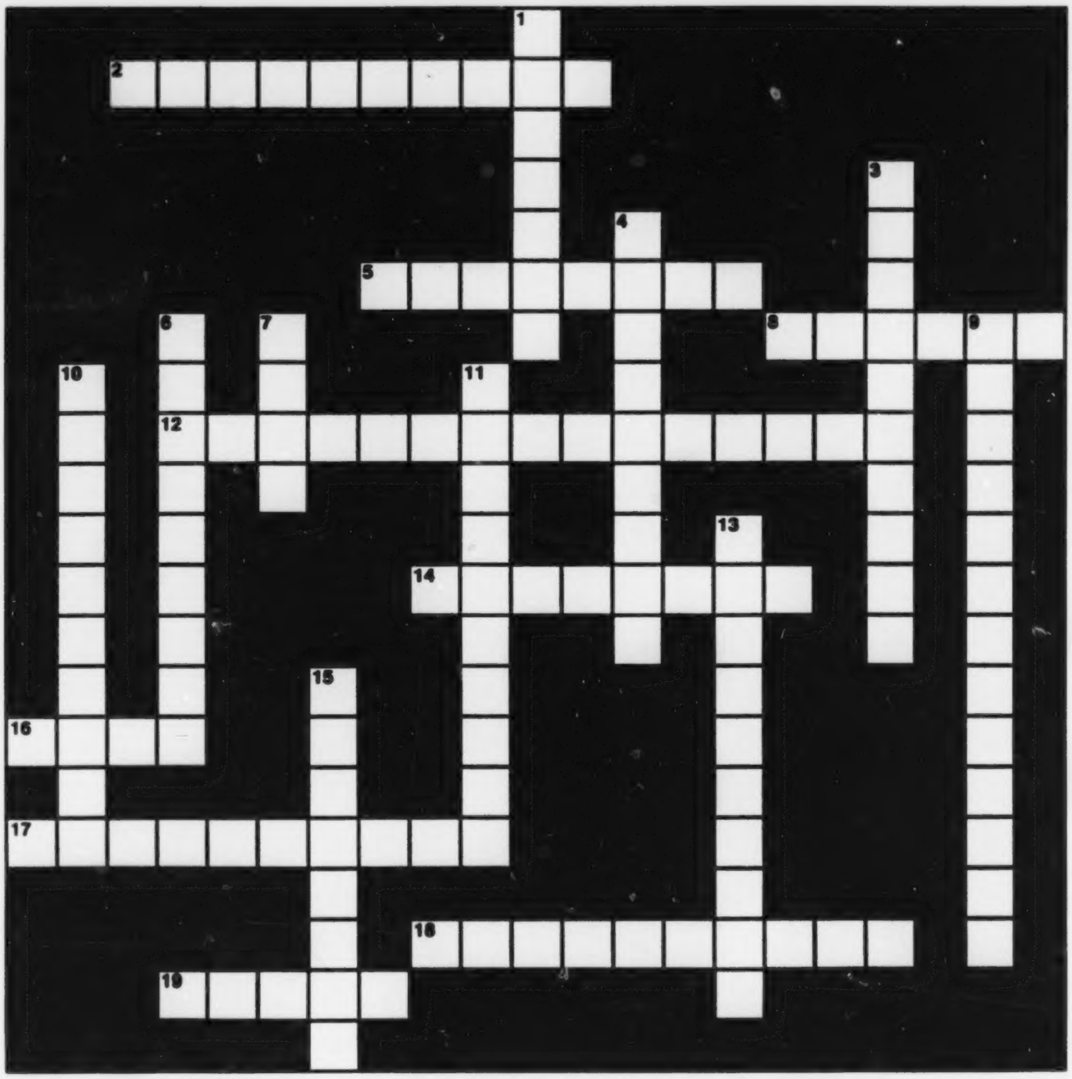
1 Type of therapy that equates personal responsibility for behavior with mental health
3 Where behavior is thought to be under the control of specific stimuli (two words)
4 Therapy where irrational beliefs are disputed and challenged (two words)
9 Life interactions based on early childhood beliefs about self and others (Berne)
10 Learning where behaviors are increased or decreased because of consequences that follow them
13 The complexities of a current situation in existential psychotherapy
16 Classical conditioning procedure for reducing anxiety

Down

2 The psychotherapeutic theory of HS Sullivan
5 The restating of a clients statements and feelings in psychoanalysis
6 Theory where the psyche is a self-regulating system with dynamic interplay between conscious and unconscious
7 Explicitly connecting present behavior to unconscious conflicts and processes
8 Horney's central principle of healthy integration and harmonious wholeness (two words)
11 Functions that are adaptive in a "conflict-free" ego
12 Primary focus of Gestalt therapy (three words)
14 Unconscious prototypes of Jungian theory
15 Type of therapy emphasizing empirical evaluation of thought patterns

482

Diagnosis 1



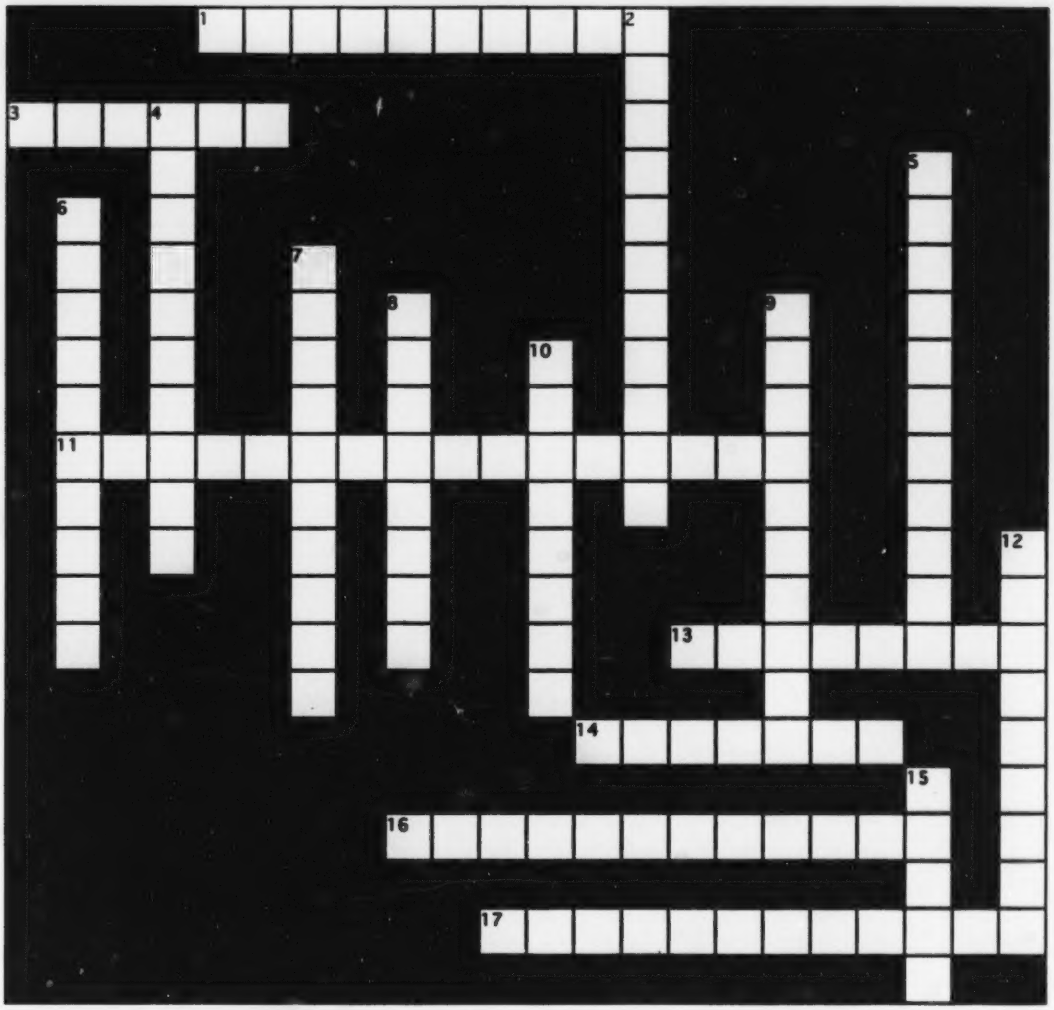
Across

2 Recurrent, intense sexual urges and fantasies toward inappropirate objects
5 Personality disorder or psychotic disorder
8 Stereotyped behavior, interests and activities with pervasive impairment in social and speech skills
12 Schizophrenic symptoms combined with major mood disorder
14 Elimination of urine at inappropriate times and/or places
16 The ingesting of inappropriate substances
17 Elimination of feces at inappropriate times and/or places
18 Intentionally feigned physical or psychological symptoms
19 Frequent regurgitating and rechewing

Down

1 Mood disorder characterized by dramatic mood swings
3 Intense sexual fantasies, urges or behavior involving touching or rubbing against a non-consenting person
4 Sudden, rapid stereotyped motor and vocal tics
6 Depressed mood, eating and sleep disturbances, low self-esteem, low energy for two years
7 Hyperactivity, impulsivity, disorganization, poor focusing
9 Class of disorders with marked impairment in reality testing, and social and occupational functioning
10 Frequent regurgitation and rechewing
11 Involuntary spasmodic contractions of female genitalia
13 Extreme need for admiration, grandiosity, & lack of empathy
15 Disorders of memory impairment

Diagnosis 2



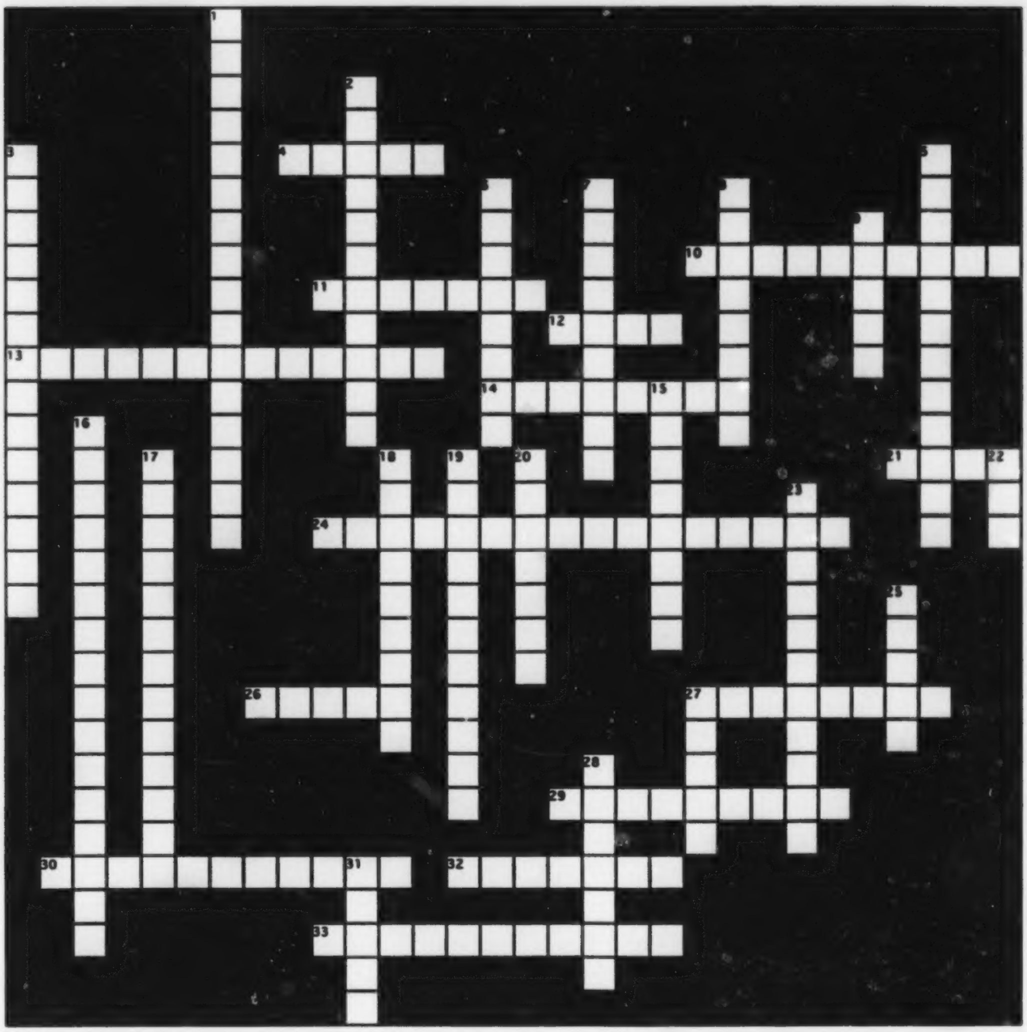
Across

1 Intentionally produced or feigned physical or psychological symptoms
3 Type of anxiety disorder
11 Recurrent pulling out of one's own hair
13 Disorder characterized by extreme social inhibition, feelings of inadequacy, fear of negative evaluation
14 Binge eating and inappropriate compensatory behavior
16 Disruptions of the integrative functions of memory, consciousness, and identity
17 Grandiosity, extreme need for admiration, lack of empathy

Down

2 Eccentricity, distortions and great discomfort in social relationships
4 Impulsivity, instability in relationships, self-image and affect
5 Recurrent or persistent genital pain associated with sexual intercourse not due to a medical condition
6 Clinically significant emotional or behavioral symptoms in response to a specific stressor
7 A dysomnia
8 Detachment from social relationships, severely restricted emotional expression
9 Actual or perceived symptoms not explained by a general medical condition
10 Refusal to maintain a minimal body weight
12 A schizophrenic disorder with marked psychomotor disturbance
15 Development of mulitple deficits following a period of normal functioning after birth

Family Therapy 1



Across

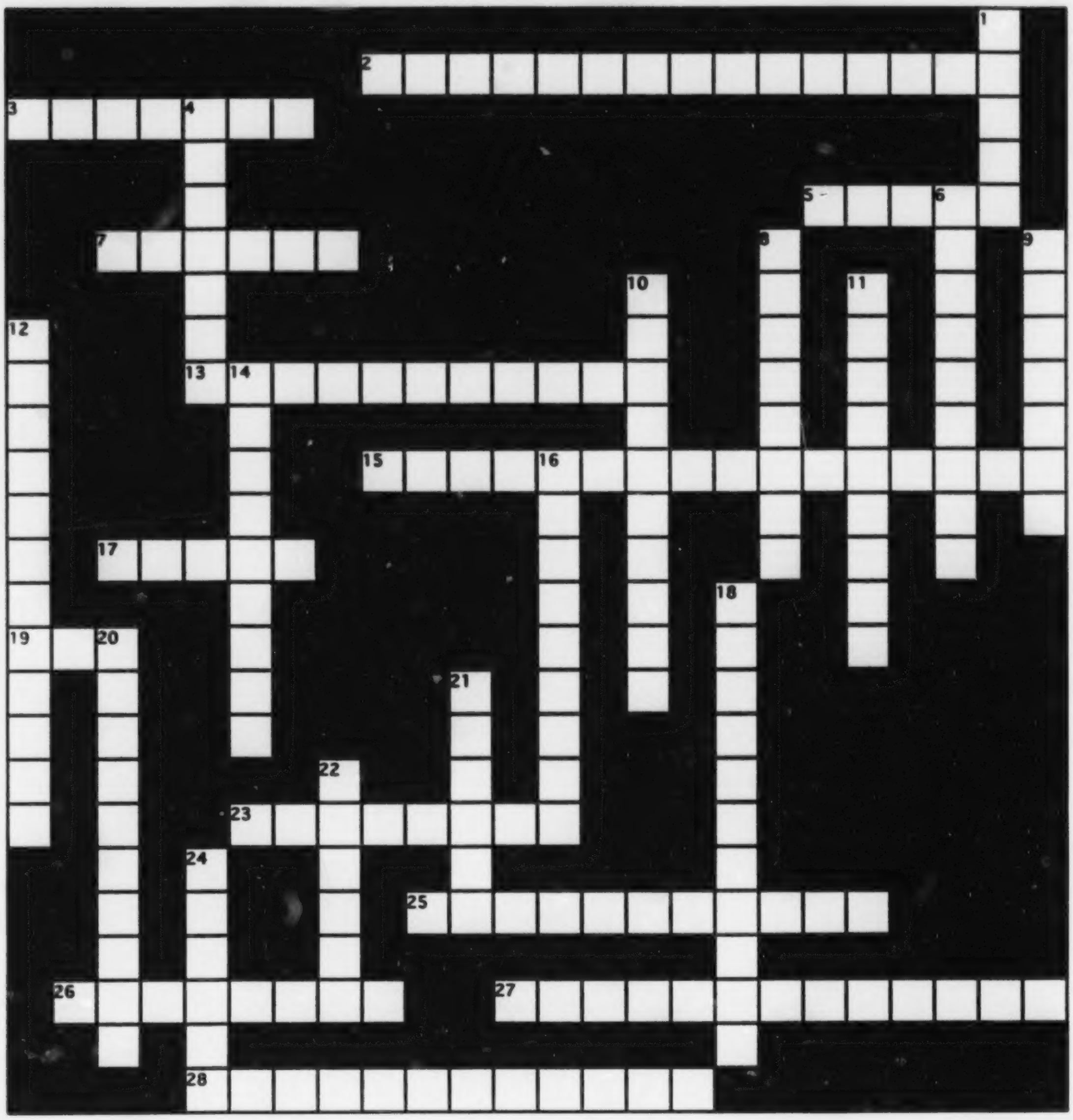
4 Considers any relationship as a power struggle
10 Seeks to create change in behavior, uses a brief therapy model
11 Is thought to be the first to apply systems thinking to family therapy
12 Began his work treating families with symptomatic children
13 Chronic discord and disequilibrium between the parents
14 Often called the grandfather of family therapy
21 Coined the term "marital skew"
24 When the family structure is very fragile it is a ________ to family therapy
26 Examines pseudo-involvements and transference projects uncovering internal part objects of family members
27 Insists on the use of co-therapists
29 A working hypothesis
30 An accommodation technique of providing family support
32 Family therapy is often referred to as a ________ theory
33 A family regulatory system

Down

1 Distracting a rigid triad with deviant behavior
2 A family regulatory system
3 The whole is equal to more than the sum of its parts
5 The same results springing from different causes
6 A multigenerational visual picture of a family
7 Each part of the system is related to its fellow parts
8 The therapist follows the families communication system and encourages them to continue
9 Created definitions of "family games"
15 Founder of Structural Family therapy
16 Upsets the existing homeostatic balance
17 The therapist adjusts to achieve joining
18 Promotes interaction using a star-shaped verbal communication pattern
19 The family meets the needs of one member of the family at the expense of others
20 The actions of the therapist aimed directly at relating to family members
22 Uses a triadic-based approach
23 The tendency for any system to react toward the restoration of the status quo
25 Coined term "family ego mass"
27 Worked primarily with Schizophrenic families at the NIMH
28 The therapist accomodates to a family's style
31 Bowenian characterization of the therapist's role

485

Group Therapy 1



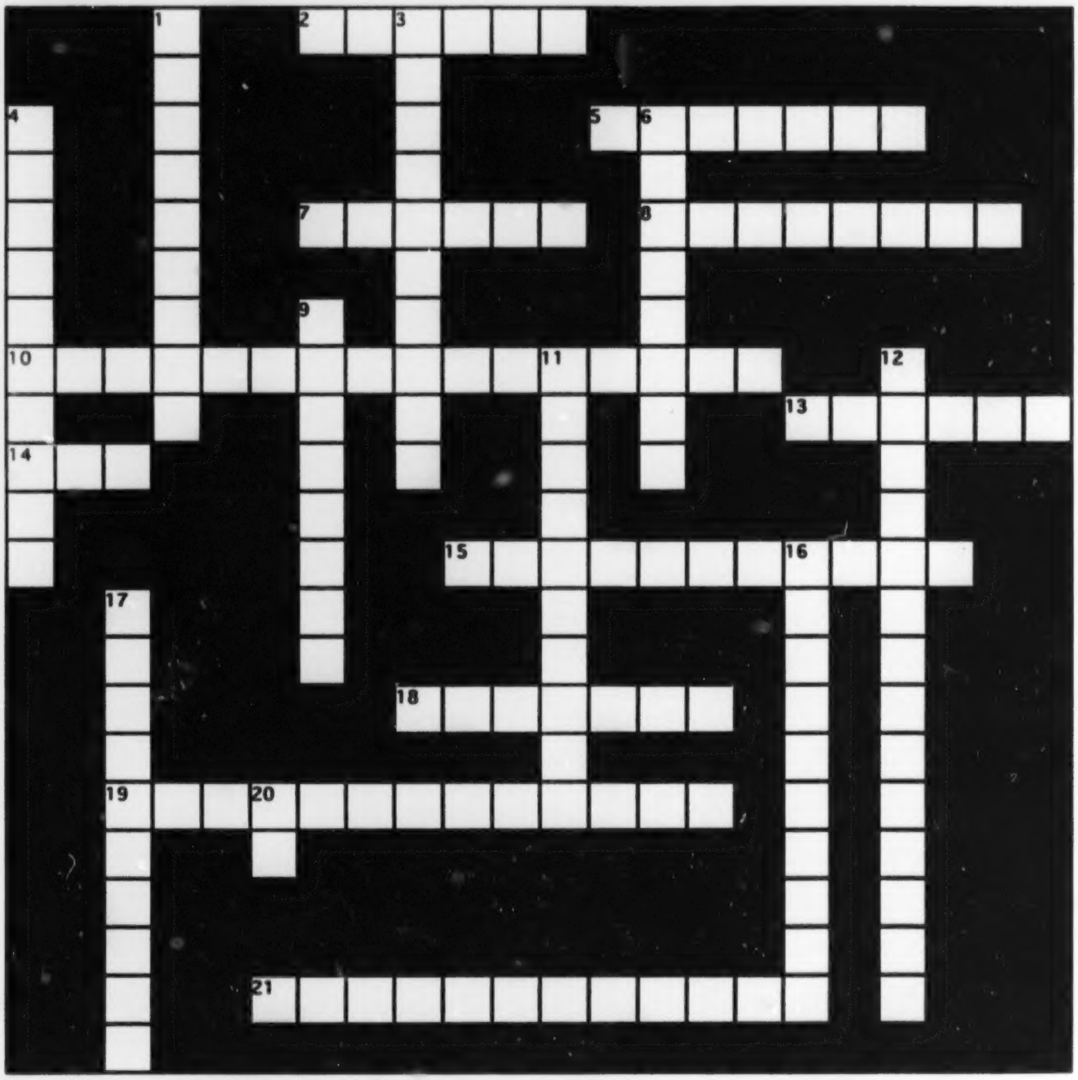
Across

2 Ellis
3 Sensing the subjective world of others
5 A set of group rules
7 Lewinof
13 Moreno
15 Poor ego structure is a ________ for group therapy
17 A major leader in the field of group therapy
19 Well known support group
23 An intervention that ends counter productive behaviors
25 Appropriate and premature
26 When group members begin to share feelings
27 Challenging others in a direct way
28 When several members of a group align against an individual

Down

1 Gestalt
4 Berne
6 When group members find that others share their conflicts
8 The second stage of the five stage model in groups
9 Looking for themes and connecting them
10 Focusing on underlying issues and getting a clear picture
11 Being able to freely express feelings
12 Helping others clarify goals
14 A visual diagram of group interactions
16 Capturing what another said and adding meaning or clarification
18 Yalom's first group stage
20 An awareness of emotions previously blocked from consciousness
21 A kind of listening that communicates to the other that they have been heard
22 Created the theater of spontaneity
24 Client centered groups

Growth & Development



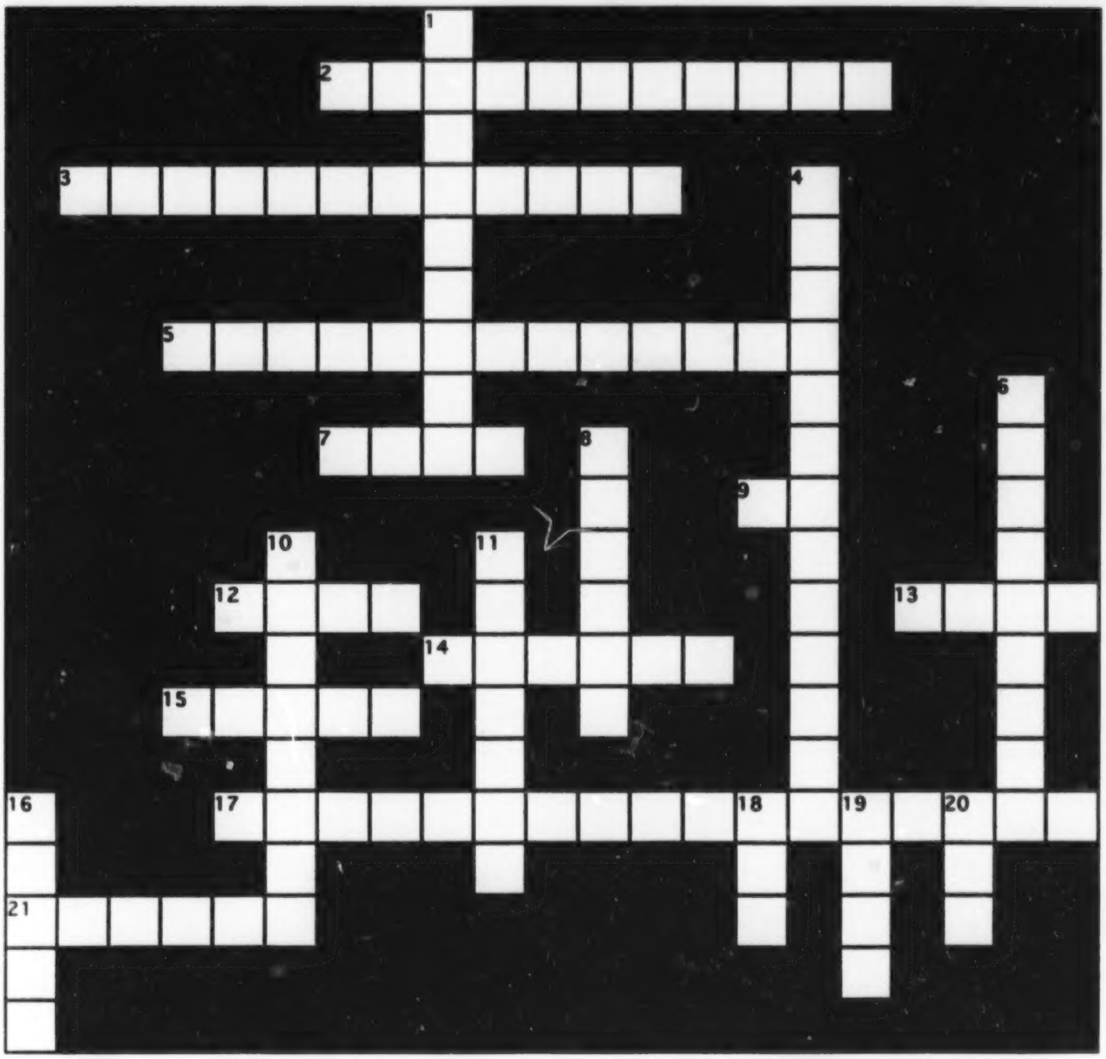
Across

2 Stage where child uses mental imagery (Bruner)
5 Official mask or pattern of behavior that a person uses in social situations
7 The refusal to see something which is a fact or true in reality
8 Opposed to shame and doubt in development
10 Preconventional, conventional & postconvential refer to (three words)
13 The stage wherein reasoning is based on logic referred to as operations
14 Primary mediating structure of the personality
15 Orientation to development seeing people as passive and reactive to external stimulation
18 Stage of development focusing on social skills
19 Primary organizing force underlying behavior (Piaget)
21 Incorporation of new knowledge into existing structures

Down

1 Smallest units of meaning in any language
3 Orientation to development postulating qualitative alterations in behavior
4 The sum total of an individual's experience (Horney)
6 Stage where child learns about the world through actions (Bruner)
9 Operational stage where objects and states can be manipulated and classified
11 Primary bond between infant & primary caretaker
12 Particular time frame where experience has greater impact
16 Type of anxiety that begins at about 1 year of age
17 Rejecting anxiety-provoking thoughts and/or feelings from consciousness
20 Source of unconscious motives and drives

Personality Theories 1



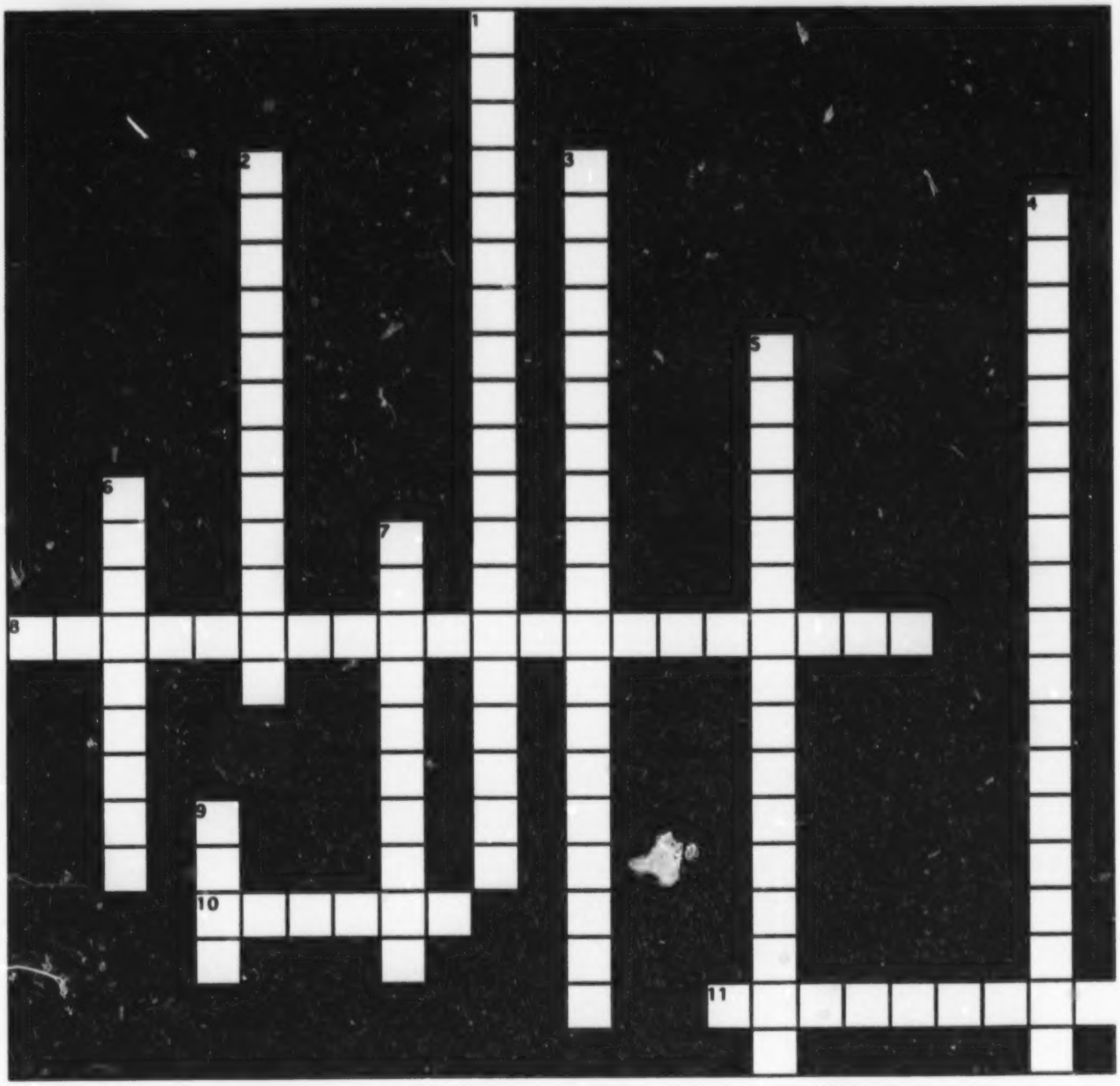
Across

2 What do these people have in common: Horney, Rank, Fromm?
3 The human capacity to create one's own personality supports (Adler)
5 Conditioning and learning is considered part of this theory
7 Key concept of Roger's personality theory
9 According to Freud, our primitive selfish aspects
12 The therapist who created the idea of the collective unconscious
13 Humanists often refer to the phrase "_____ experience"
14 Theorist who proposes client-centered therapy
15 Perceived people as being selfish, impulsive and irrational
17 The social learning theorist's equivalent to the Freudian concept of Superego is_____.
21 One of two of Freud's motivational instincts

Down

1 Self actualization refers to one making full use of their _____.
4 Internal conflicts
6 Learning sex appropriate behavior is influenced by identification and_____.
8 Theorist who holds the greatest similarity of viewpoint with Freud
10 According to Freud, aggressive urges are the result of the
11 Experiences that are incongruent with self-image are often
16 Theorist that believes we start out life small, weak and powerless
18 Cognitive restructuring is the technique
19 Freud's term for life instincts
20 In psychoanalytic theory conscious control is experienced by the ____.

Prevention



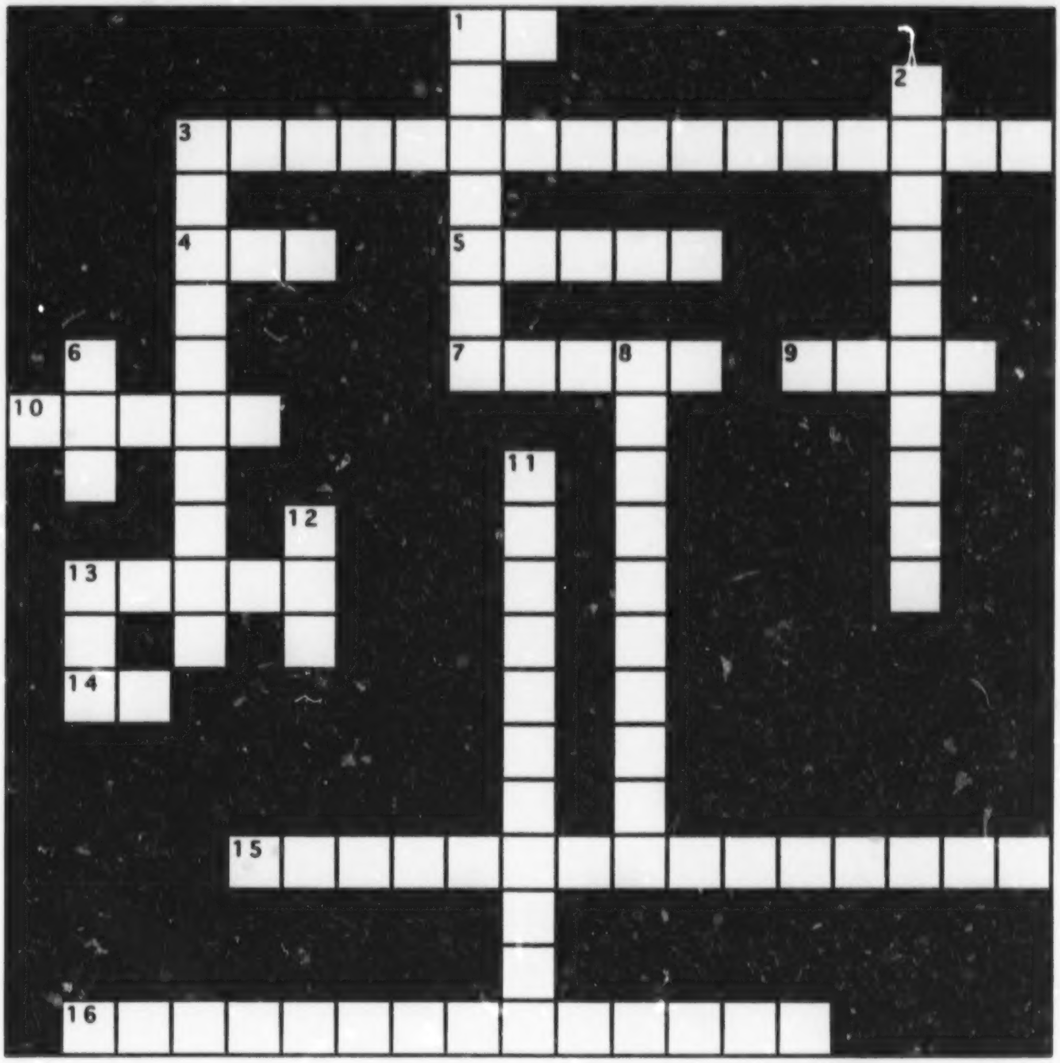
Across

8 How one grows across the life span
10 Institutional factor
11 Occupational setting

Down

1 Window of opportunity
2 Sequences in family development and the relationships between parents
3 Planned program of interventions
4 Gene risk
5 Individual and environmental
6 A focus of interventions
7 Identification with delinquent youth group
9 The greater the number the higher the degree of risk to mental illness

Professional Practice 1



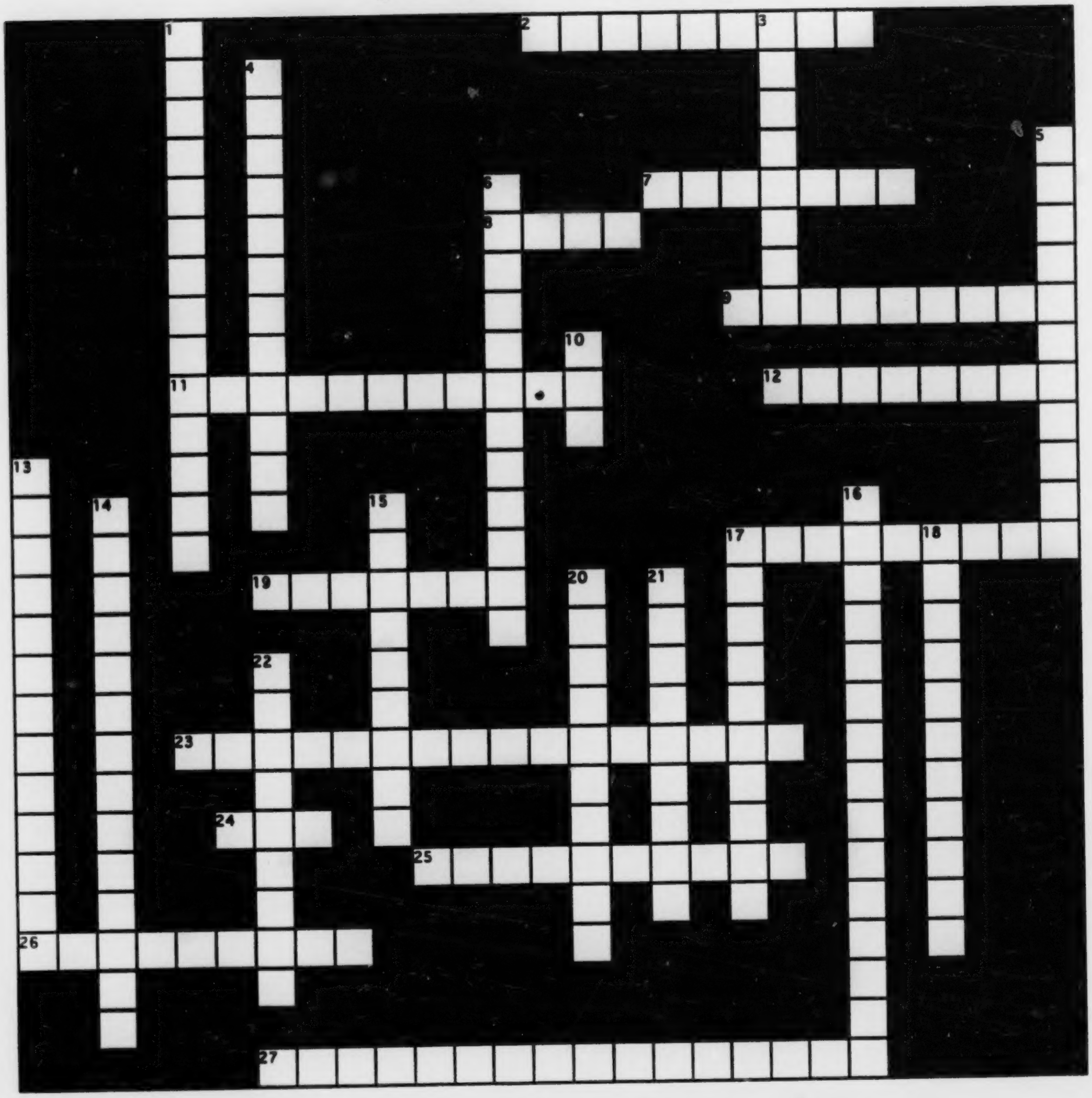
Across

1 Utilization
3 When you have another role other than counseling in your client's life
4 How many locks do your records need to be kept behind?
5 Fiduciary, physical, neglect, abandonment are a pattern of abuse of an ________
7 You are legally bound to work within the ________ of your practice
9 A type of clinical note that is recommended for clinicians
10 A person who has not been emancipated
13 After how many visits do you need to make a clinical evacuation and treatment plan?
14 Diagnosis
15 One of your client's rights
16 Keeping all communications private

Down

1 If your client is not making progress you could be guilty of __________ treatment
2 Neglect and abandonment of a minor
3 One of the many times you break confidentiality is when there is a _________.
6 Four times a day
8 An exchange of information between two people that is confidential is a _________ communication.
11 When your client's benefits run out, if you do not offer treatment options, you are guilty of __________ ?
12 Before you engage in treatment you must disclose this to your new client
13 Three times a day

Psychopharmacology



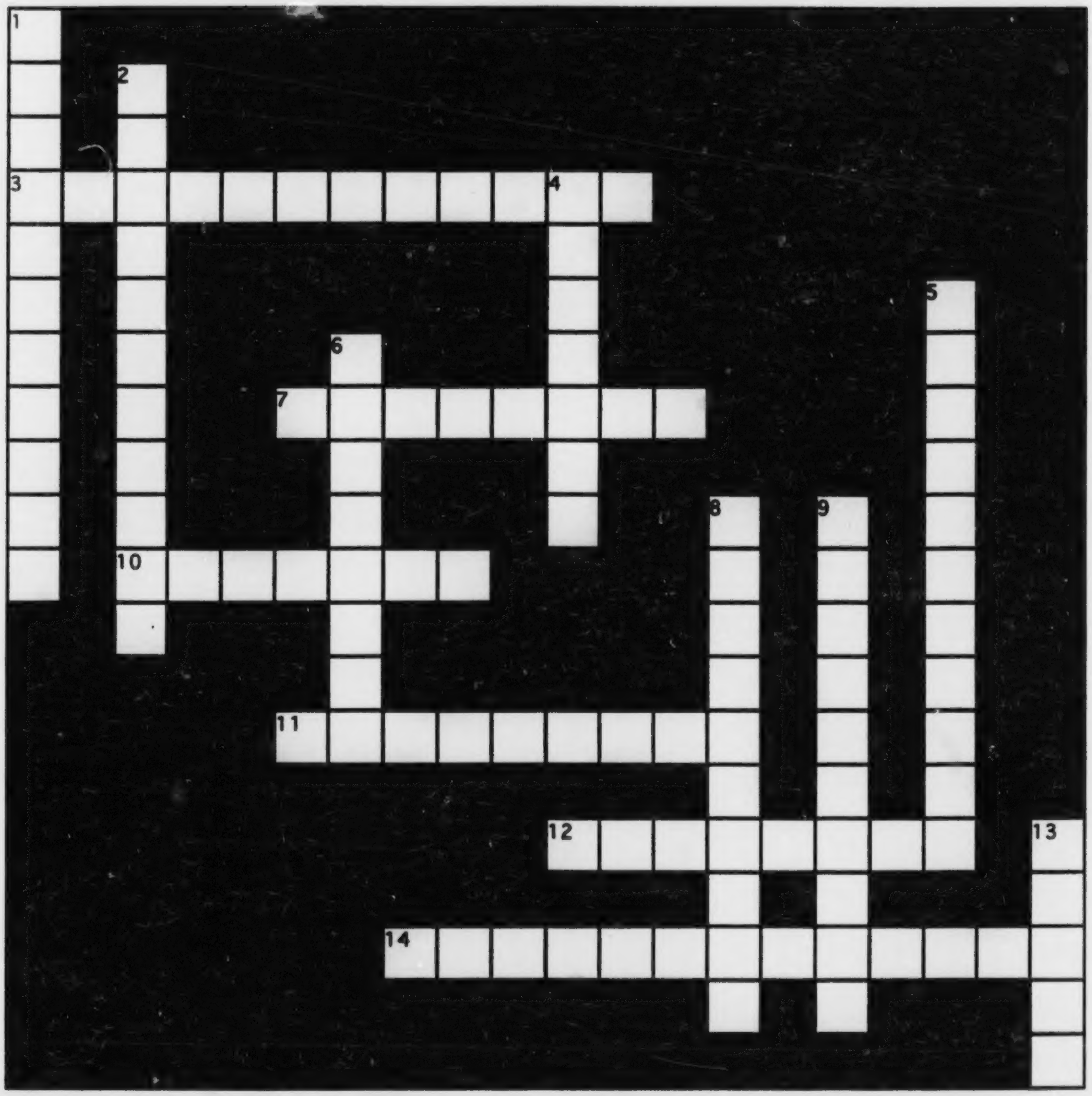
Across

2 Anticholinergic reaction
7 Affects the renal system and needs to be closely watched
8 A syndrome often treated with Amphetamines
9 A pure synthetic opioid
11 When an abnormally low blood pressure results from standing one is considered to have ____ hypotension
12 Lack of muscle tone
17 A reduced response to a drug resulting from repetitive use
19 Once used as a cure for Heroine addiction
23 How a drug is distributed in the body
24 The psychoactice ingredient in Cannabis
25 A compulsive need to use a drug
26 The increase of the effect of a substance combined with another
27 How a drug begins its affects at its action site

Down

1 Block psychosis
3 A natural opioid
4 Block dopamine receptors in the brain
5 CNS stimulant
6 A small amount of alchohol with a modest dose of ________ can be lethal
10 One of the most dangerous hallucinogens
13 Navane and Haldol
14 Thorazine, Mellaril, Stelazine
15 A reaction sometimes seen from use of hallucinogens
16 Valium, Librium and Serax
17 Antidepressents such as Sinequan and Tofranil
18 Antianxiety agents
20 A compulsive need to use a drug
21 Barbituates, alcohol, opiates
22 An inner restlessness

Research



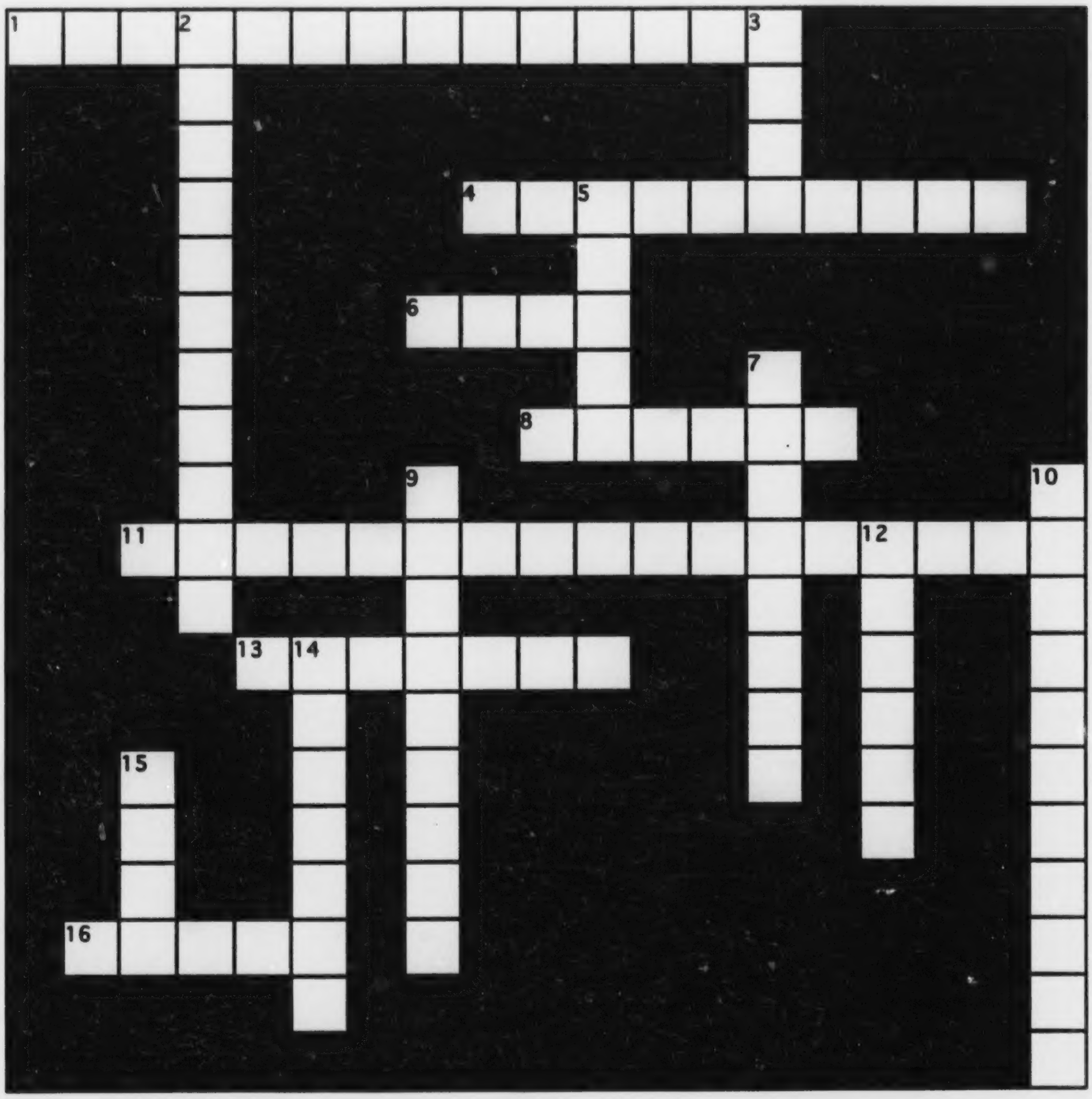
Across

3 Research in which there is a control group and independent variables
7 Method used to select subjects from the population of interest
10 Sampling bias, personal rigidity of the experimentor, and faulty definition are examples of_____.
11 Variables that are characteristics or phenomena being tested for
12 Research Phase A in which no treatment is given
14 Threats to the validity of a study are called_____.

Down

1 Variables that are believed to be the cause of the chance or variation in question
2 Research design in which the independent variable has changed, but not by manipulation of the researcher (three words)
4 Research done in a naturalistic setting
5 Research without inference regarding cause and effect
6 Any aspect of a person, group, or setting that is measured for the purposes of the study in question
8 A statement relating to the study that needs to be proved
9 Research that is the reconstruction of past events to arrive at conclusions
13 When research has rigorously controlled setting & the focus is theoretical

Statistics



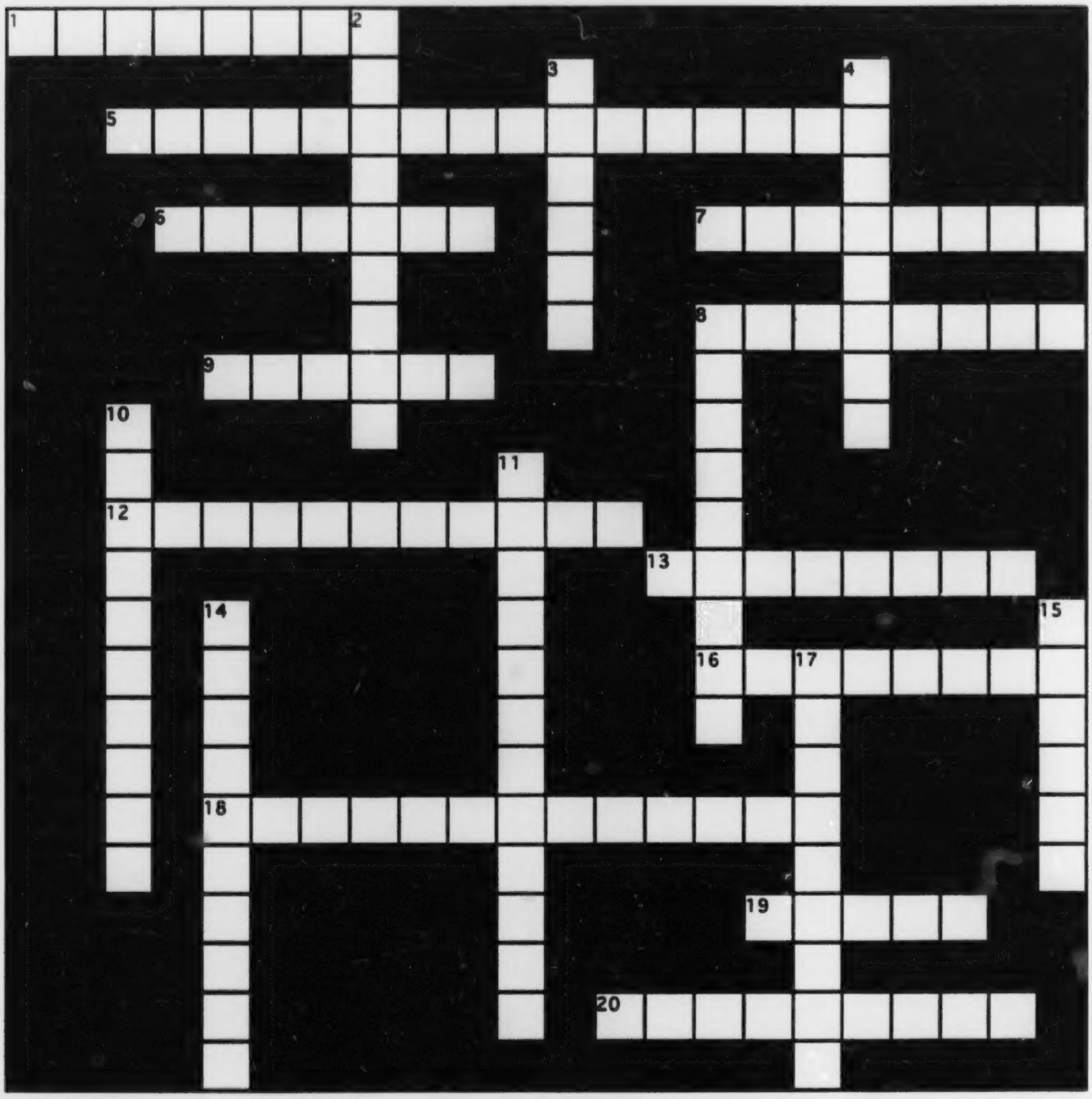
Across

1 Number of values or categories in a distribution free to vary (2 words)
4 Type of statistic used when sample is randomly obtained and normally distributed around mean
6 Balance point of a set of scores
8 Score that divides a set of data in half
11 Measure of variablitly in relation to the mean (2 words)
13 Scale that distinguishes groups, not reflecting differences in magnitude
16 Significance level set by researcher

Down

2 Reflects the accuracy of a test
3 Score occuring most often in a set of data
5 Simplest measure of variablity, subtracting lowest score from highest
7 Refers to a test's usefulness
9 Measure of variablilty indicating how scores differ from one another
10 Type of statistic including ANOVA, Chi Square and others
12 Most commonly used standard score
14 Type of scale where information ranked greatest to least
15 Hypothesis stating that no relationship exists between variables

Substance Abuse 1



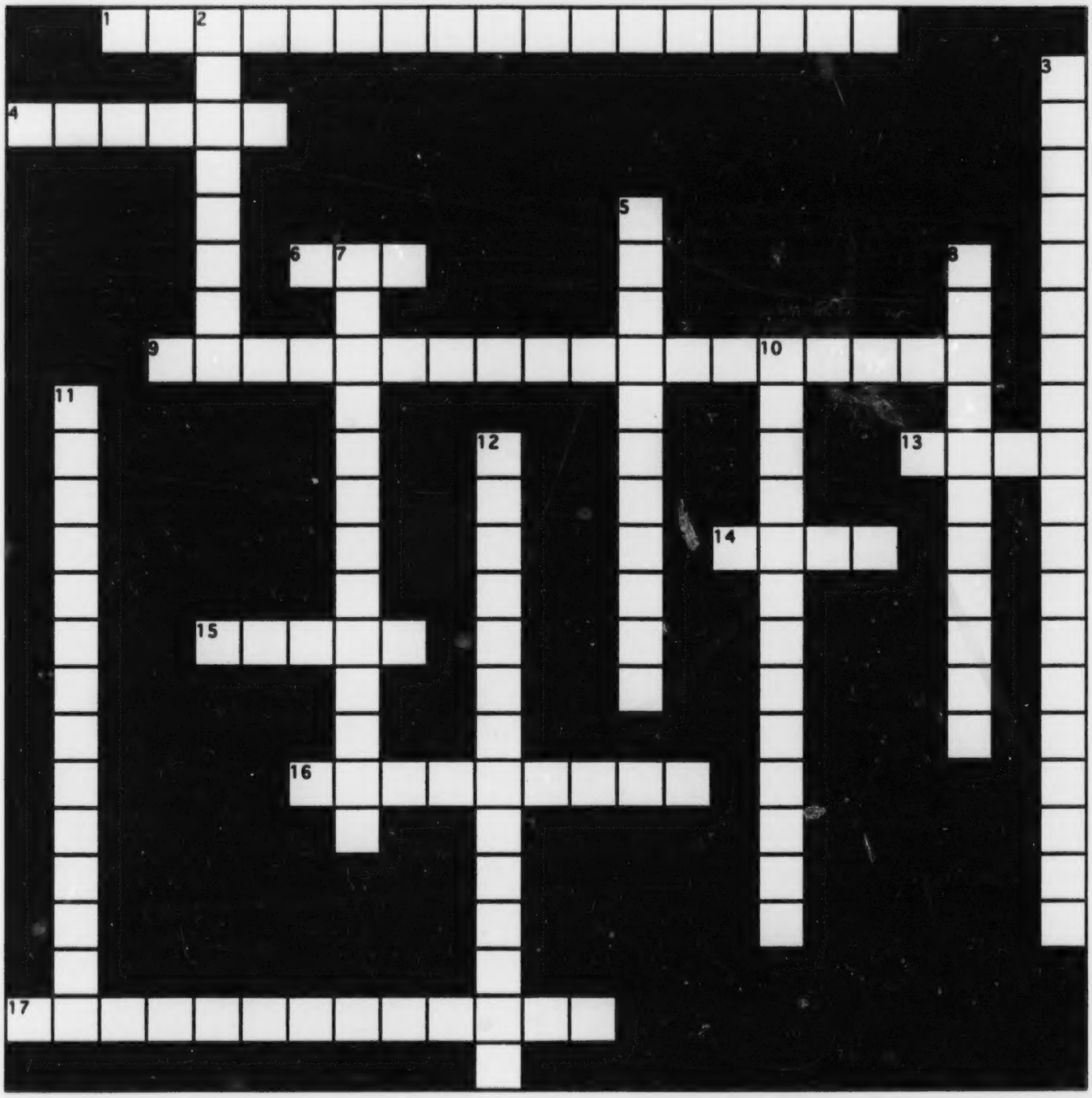
Across

- 1 Is often difficult to develop therapeutic relationship with this abuser
- 5 First stage of treatment with substance abuse
- 6 Depressant
- 7 First stage of substance abuse
- 8 A vitamin used in treatment of alcoholics
- 9 The arena that supports early substance use
- 12 Using a substance for longer than intended
- 13 A therapeutic intervention used with hallucinogen users
- 16 A substance almost everyone consumes daily
- 18 Patients are often severely and chronically mentally ill
- 19 Presumes no prior diagnosis of dependence
- 20 The use of a substance to relieve or avoid withdrawal symptoms

Down

- 2 A blending of senses
- 3 Methadone used as an intervention
- 4 Can be life threatening
- 8 Need for more to achieve similar results
- 10 Tolerance, Withdrawal, Persistence
- 11 Reversible syndrome, substance specific
- 14 The use of a substance to relieve or avoid withdrawal symptoms
- 15 The first most difficult issue to address in treatment
- 17 Often happens after chronic use of hallucinogens

Substance Abuse 2



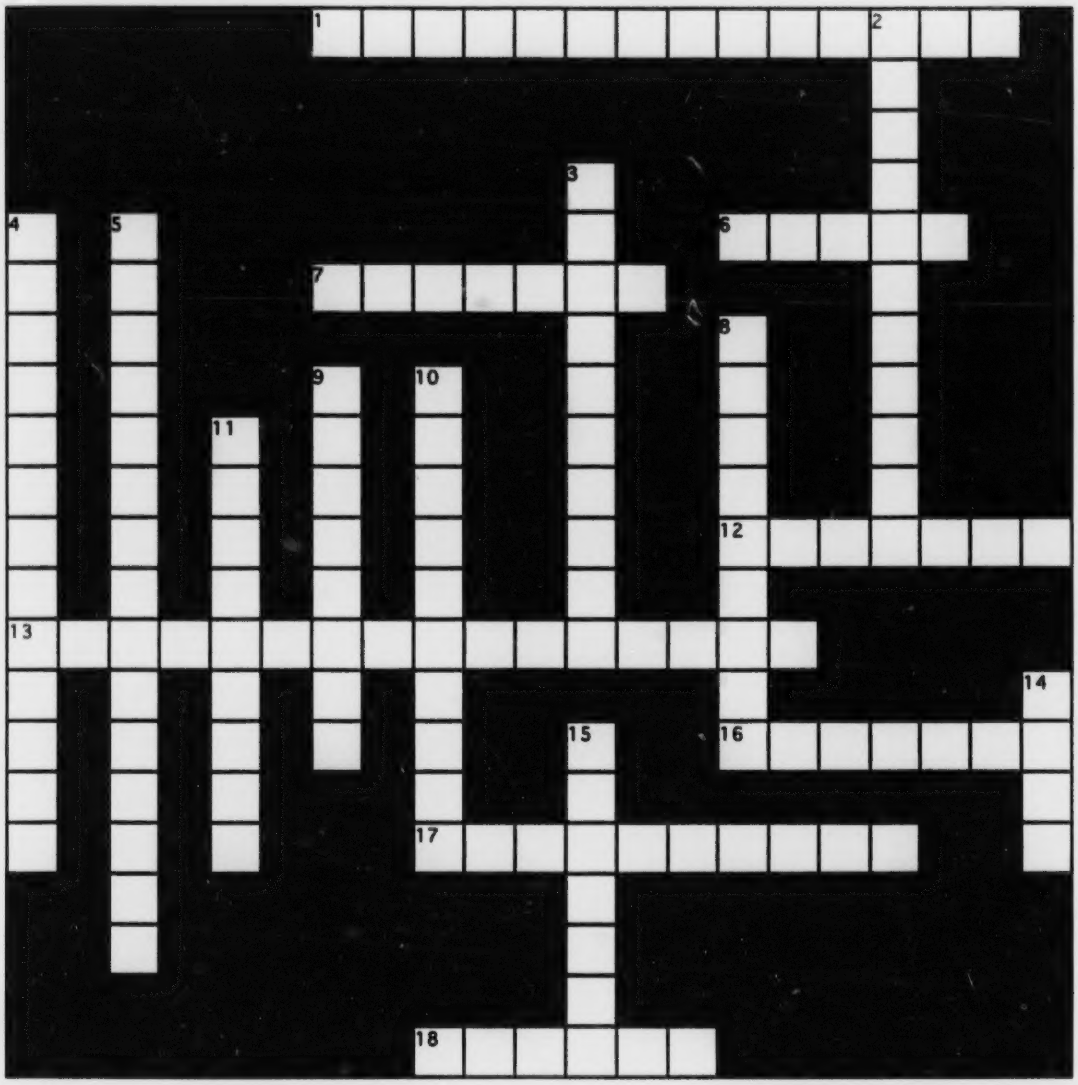
Across

1 Reassurance, Anxiety relief, Anxiolytics
4 Preabuse, Experimental, Regular, End
6 Phencyclidine
9 Scale and Symptom development
13 Self report questionnaire
14 Hallucinogen
15 Benzodiazepine
16 Need for greater amounts to achieve similar results
17 Symptom reemerges

Down

2 Antabuse
3 Individual symptoms for each substance or the use of the substance to relieve or avoid withdrawal symptoms
5 Unintended use of larger amounts or for longer than intended
7 Acknowldgement of personal responsibility with minimal willingness to change
8 The decision point
10 Coexistence of a major psychiatric illness and substance dependence or abuse
11 Presumes no prior diagnosis of dependence and does require impairment or distress from a maladaptive pattern within a 12-month period
12 Drug is withdrawn and symptoms reappear

Treatment Issues



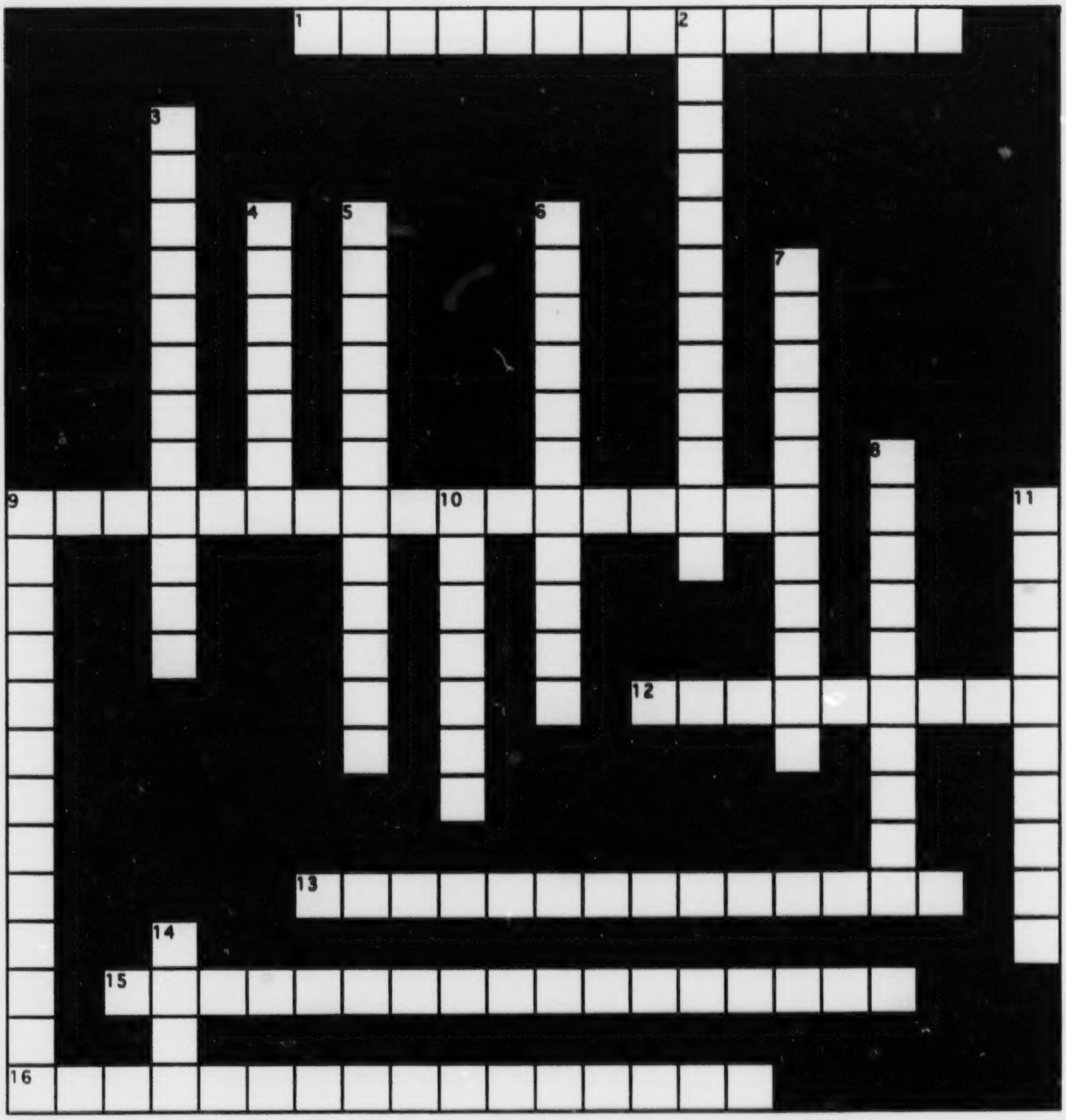
Across

1 Causes depression in the elderly (2 words)
6 Type of issues important for therapist with suicidal client
7 Leads to higher rates of child mal-treatment
12 Respect for these clients is especially important in working with them
13 Can be a characteristic of abusive parents (2 words)
16 No accurate way of predicting this phenomenon has been found
17 Type of play seen more in abused children
18 A child victim is more seriously affected than other trauma victims

Down

2 Young girls and older boys are the most common victims
3 Type of interpersonal behavior sometimes exhibited by abused children
4 Abused children feel more of this attribute (3 words)
5 Awareness of diversity is important in working with this group (2 words)
8 Can appear charming and affable outside of home
9 Focus on affect in early stages of treatment is important for this group
10 Absence of role models is difficult for this group (2 words)
11 Continues with persons into their eighties and beyond
14 Treatment modality used for suicidal clients
15 These parents have misperceptions of their child

Treatment Planning



Across

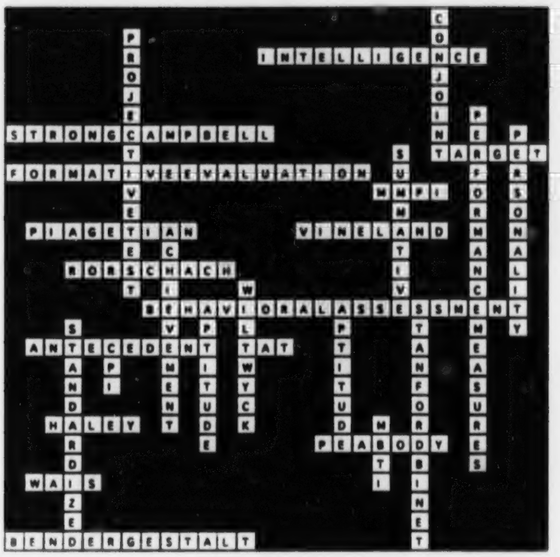
1 Group treatment with a strong leader is helpful
9 Treatment includes client and family (2 words)
12 Persons with personality disorders are often_____.
13 These problems may be ego-syntonic
15 Clients should be followed closely by neurologist and psychiatrist (2 words)
16 Disorders where "package plan" is most effective in treatment

Down

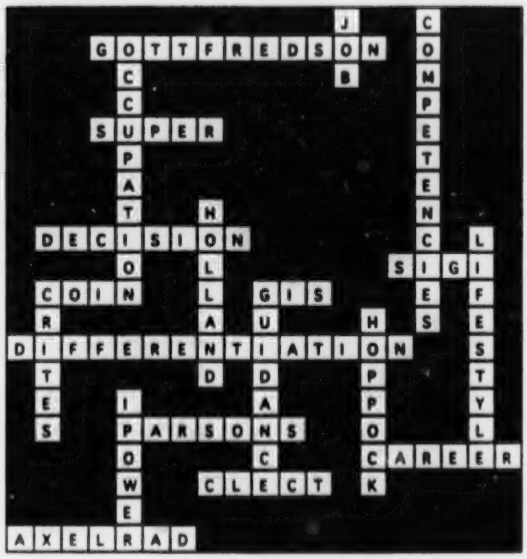
2 Disorder for which medication is primary mode of treatment
3 Disorder where treatment includes exploration of original trauma
4 Personality group for which initial treatment must be especially careful and deliberate
5 Personality group most resistant to treatment (2 words)
6 Treatment used with sleep disorders (2 words)
7 Axis II disorders are generally (2 words)
8 Disorder where therapist helps find new resources and supports
9 Psychotherapy with medication if problem is severe (2 words)
10 Behavioral and cognitive treatment is especially helpful
11 Disorder where therapist and physician must work closely together
14 Issues important to disorders due to a medical condition

Answers

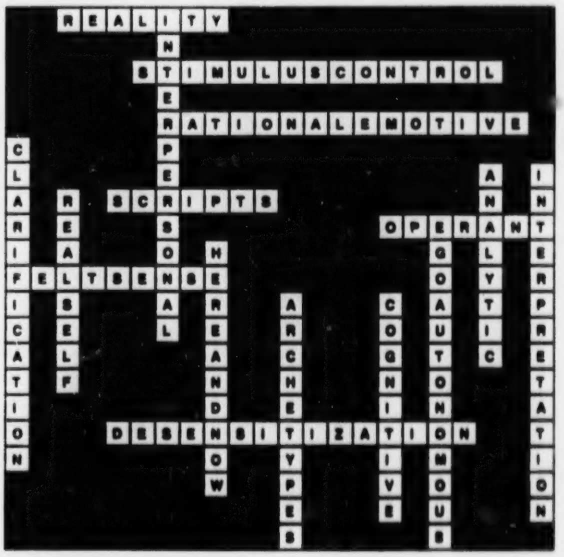
Assessment 1



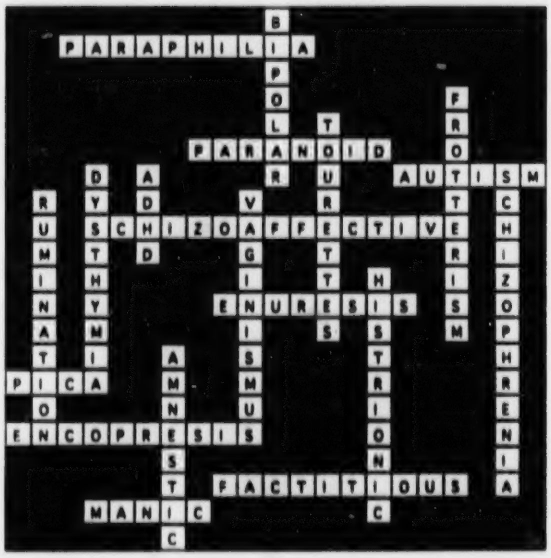
Career



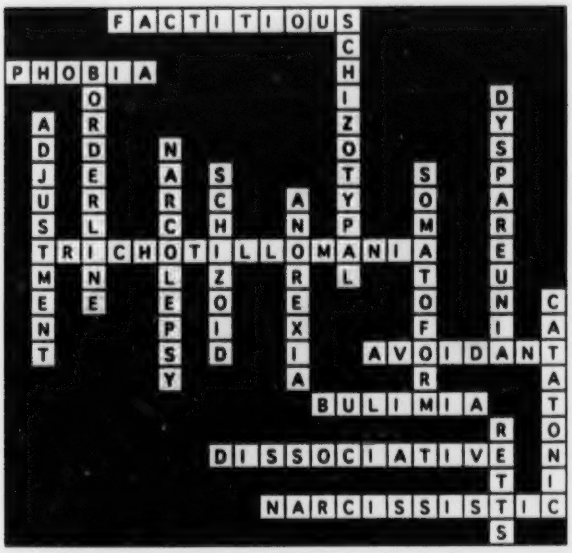
Counseling Theories



Diagnosis 1



Diagnosis 2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BORDERLINE
ADJUSTMENT
NARCOLEPSY
SCHIZOID
ANOREXIA
SOMATOFORM
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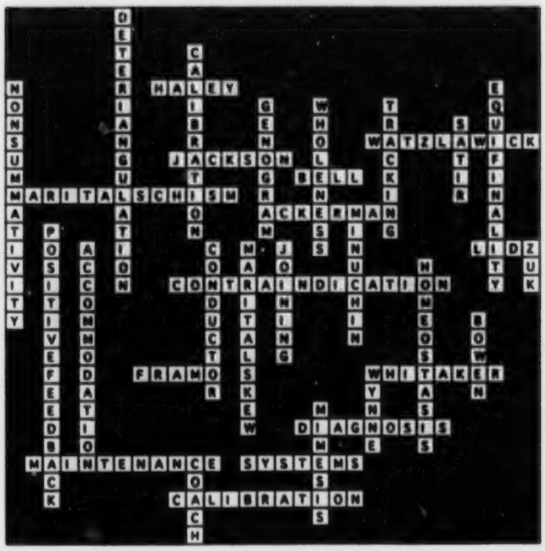
TRICHOTILLOMANIA
CATATONIC
AVOIDANT
BULIMIA
RETTS
DISSOCIATIVE
NARCISSISTIC

Family Therapy 1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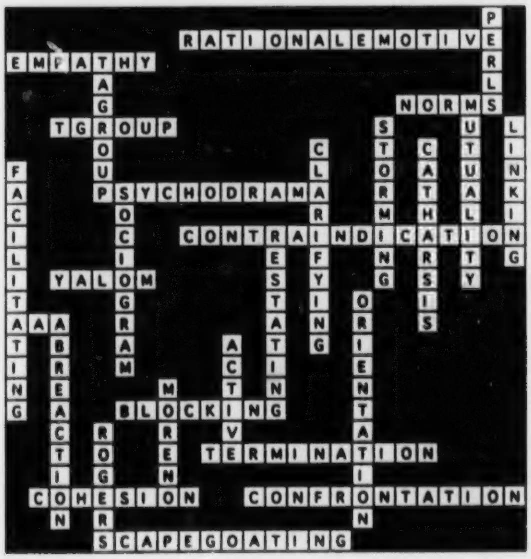
CALIBRATION
HALEY
NONSUMMATIVITY
GENOGRAM
WHOLENESS
TRACKING
EQUIFINALITY
SATIR
WATZLAWICK
JACKSON
BELL
MARITALSCHISM
ACKERMAN
MINUCHIN
LIDZ
ZUK
POSITIVEFEEDBACK
ACCOMMODATION
CONDUCTOR
MARITALSKEW
JOINING
CONTRAINDICATION
HOMEOSTASIS
BOWEN
FRAMO
WHITAKER
WYNNE
MIMESIS
DIAGNOSIS
MAINTENANCE
SYSTEMS
COACH
CALIBRATION

Group Therapy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EMPATHY
TAGROUP
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STORMING
CATHARSIS
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CLARIFYING
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SOCIOGRAM
CONTRAINDICATION
FACILITATING
YALOM
RESTATING
ORIENTATION
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ACTIVE
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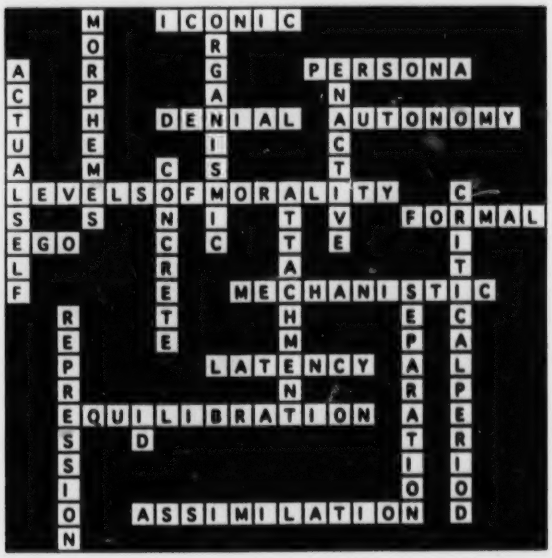
BLOCKING
ROGERS
TERMINATION
COHESION
CONFRONTATION
SCAPEGOATING

Growth & Development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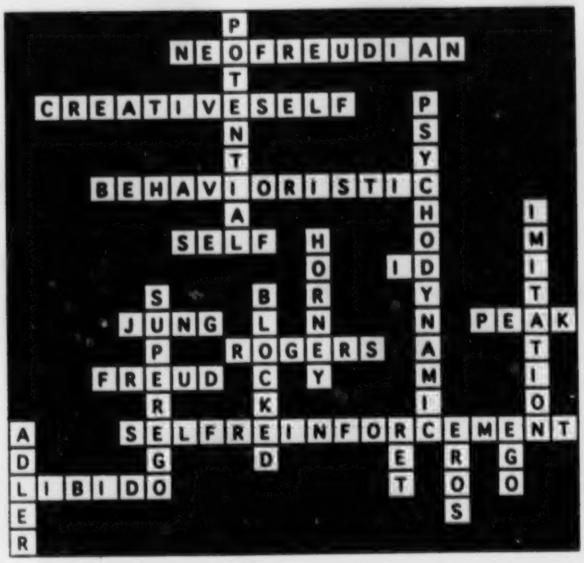
CRITICALPERIOD
FORMAL
EGO
ATTACHMENT
MECHANISTIC
SEPARATION
REPRESSION
LATENCY
EQUILIBRATION
ID
ASSIMILATION

Personality Theories 1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SELF
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ID
IMITATION
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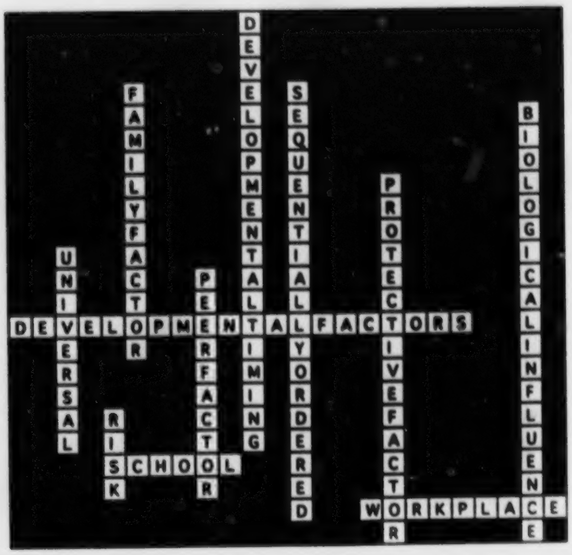
BLOCKED
ROGERS
FREUD
SELFREINFORCEMENT
EROS
EGO
LIBIDO
ADLER

Prevention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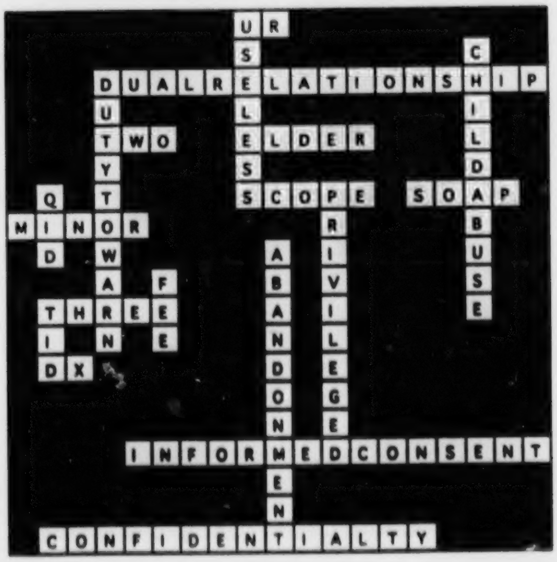
DEVELOPMENTALFACTORS
RISK
SCHOOL
WORKPLACE

Professional Practice 1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CHILDABUSE
DUALRELATIONSHIP
DUTYTOWARN
TWO
ELDER
SCOPE
SOAP
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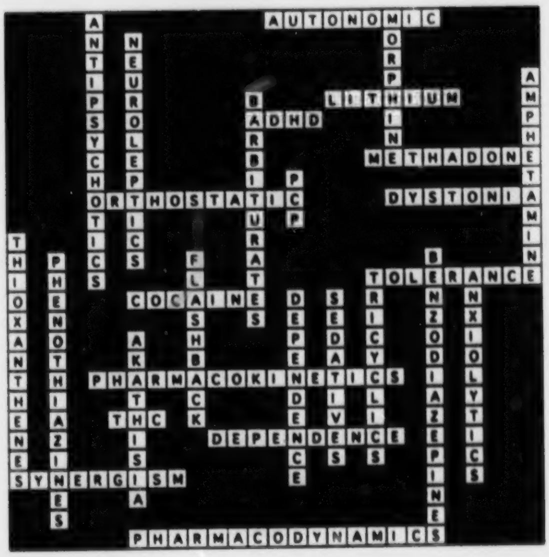
QID
MINOR
THREE
FEE
TID
DX
ABANDONMENT
INFORMEDCONSENT
CONFIDENTIALTY

Psychopharmacology


ANTIPSYCHOTICS
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BARBITURATES
ADHD
AMPHETAMINE
METHADONE
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ORTHOSTATIC
DYSTONIA
TOLERANCE
BENZODIAZEPINE
ANXIOLYTICS
COCAINE
FLASHBACK
SEDATIVES
TRICYCLICS
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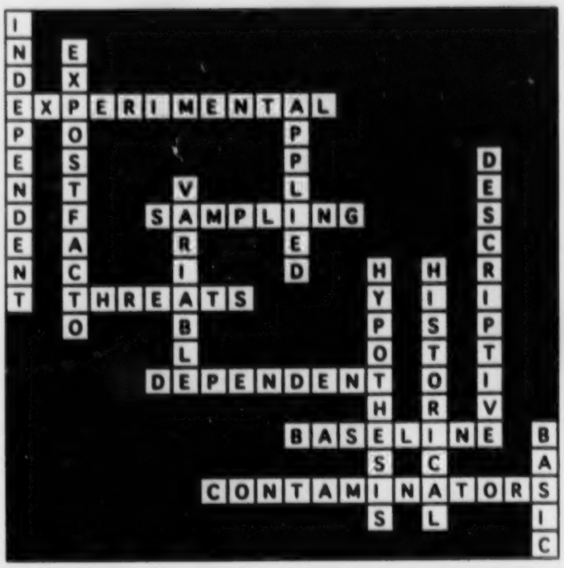
PHENOTHIAZINES
SYNERGISM
PHARMACODYNAMICS

Research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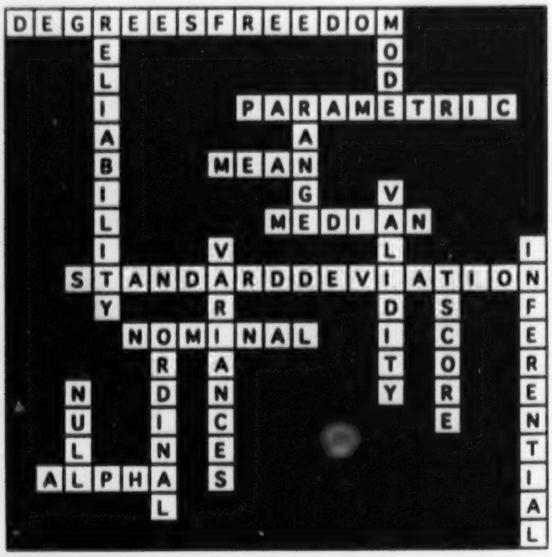
BASELINE
BASIC
CONTAMINATORS

Statistics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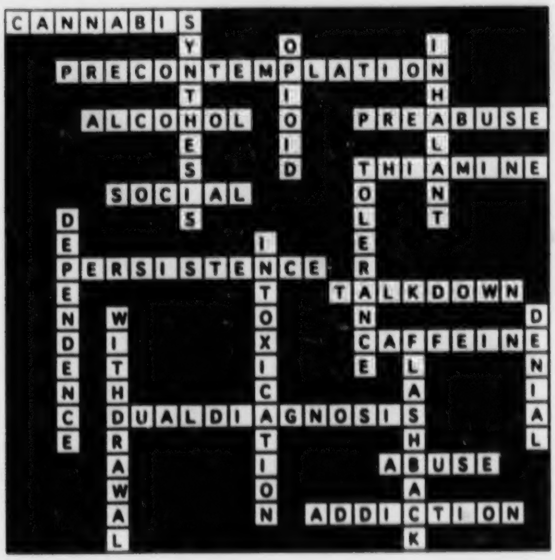
ORDINAL
NULL
ALPHA

Substance Abuse 1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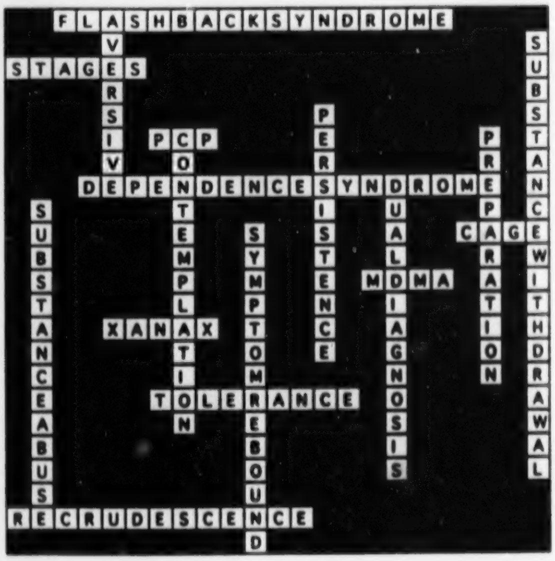
CAFFEINE
FLASHBACK
DUALDIAGNOSIS
ABUSE
ADDICTION

Substance Abuse 2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STAGES
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PCP
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PREPARATION
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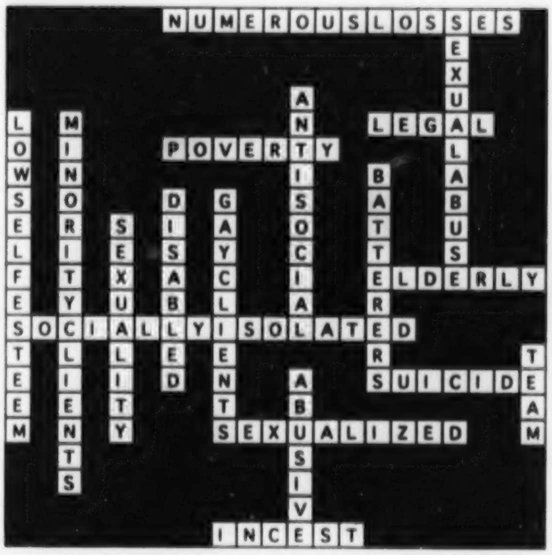
CAGE
MDMA
SUBSTANCEABUSE
SYMPTOMREBOUND
XANAX
TOLERANCE
RECRUDESCENCE

Treatment Issues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TEAM
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ABUSIVE
SEXUALIZED
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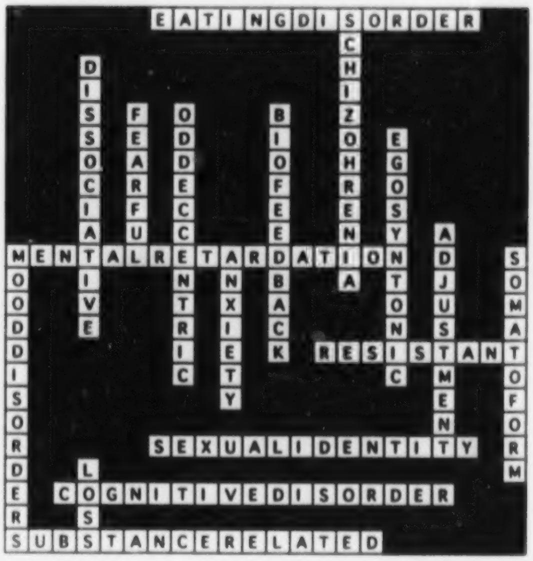
Treatment Planning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ADJUSTMENT
SOMATOFORM
MOODDISORDER
RESISTANT
SEXUALIDENTITY
LOS
COGNITIVEDISORDER
SUBSTANCERELATED

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